

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13371

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13374

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204				d. STREET ADDRESS Ebenezer Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last AFFELD				4. DATE OF DEATH Month October Day 29 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 10-31-98		
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Ownbusiness		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John R. Affeld				14. MOTHER'S MAIDEN NAME Mary Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-01-5759		17. INFORMANT Address Mrs Marie E. Affeld Ebenezer Road White Marsh			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction - white thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from 10-27 , 19 67 , to 10-29 , 19 67 , that (X) (we) last saw the deceased alive on 10-29 , 19 67 , and that death occurred at 2:28 P M, from causes and on the date stated above.								
22a. SIGNATURE William				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-29-67		
22c. PHYSICIAN'S NAME (Type) Ines Cilliani M.D.				22d. ADDRESS 7620 York Road, Towson, Maryland 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-1967		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery Joppa, Md.		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Joseph Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR DATE NOV 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

1934

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13372					13375				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Baltimore		Catonsville			Maryland		Anne Arundel		
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
		Forest Haven Nursing Home			Severna Park		Rte. 2, Box 114		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		e. IS RESIDENCE ON A FARM?		
Edith Aiken					Oct. 31, 1967		YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Apr. 24, 1875		72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Dressmaker				Ret.		Baltimore,		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Matthew Kelly					Virginia Jerome				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT		
NO					214-20-0334		Mary H. Seaman Same as 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4201 MYocardial INFARCTION									
DUE TO (b) HYPERTENSIVE CARDIO-VASCULAR									
DUE TO (c) DISSEMINATED									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 7/1, 1962, to 10/31, 1967, that (I) (we) last saw the deceased alive on 10/31, 1967, and that death occurred at 6:20 PM, from the causes and on the date stated above.									
22a. SIGNATURE								22b. DATE SIGNED	
John Shaw, M.D.								11/1/67	
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS	
John Shaw, M.D.								5800 Edmondson Ave. Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		11-3-67		Greenmount Cemetery		Baltimore		Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Kirkley Funeral Home, 421 Grain Hwy., S.E., Glen Burnie, Md. 21061						NOV 3 1967		J. Charles Judge	

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13373 CERTIFICATE OF DEATH 13376

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b 3 weeks		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 7028 Yataruba Drive	
3. NAME OF DECEASED (Type or print) First Annie Middle W. Last Albert		4. DATE OF DEATH Month Oct. Day 23 Year 1967	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1888
9. AGE (in years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 03 Days 1 IF UNDER 24 HRS: Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Conrad Roemer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-5729 D	
17. INFORMANT Mrs. Donald LeBlanc		Address 7028 Yataruba Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome 4201 DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Heart Disease with recent myocardial necrosis, prob. infarct DUE TO (c) Myocardial necrosis, prob. infarct			INTERVAL BETWEEN ONSET AND DEATH 3 months One month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 to 10-24 1967 , that (I) (we) last saw the deceased alive on 10-24 1967 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Rafael A. Perez-Mera		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Rafael A. Perez-Mera, M.D.		22d. ADDRESS 7306 Liberty Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR G. Vernon Lemmon		ADDRESS 4611 Park Heights Av. Balto.	
25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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VR A15 (4)
25M 1/67

13374				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13377			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY <u>Baltimore</u> MARYLAND				a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxliegh</u>				d. STREET ADDRESS <u>11127 Reisterstown Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH							
First <u>Irene</u> Middle <u>G.</u> Last <u>Allard</u>				Month <u>October</u> Day <u>16</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18, 1894</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>			
13. FATHER'S NAME <u>William Southworth</u>				14. MOTHER'S MAIDEN NAME <u>Alwilda Garnett</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates at service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-10-0976D</u>				17. INFORMANT Address <u>Mr. Aubrey C. Allard Baltimore 20, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of colon</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>9-19</u> , 19 <u>67</u> , to <u>10-16</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>10-15</u> , 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>David I. Miller</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>10-16-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>				22d. ADDRESS <u>Lisbon Rd. Owings Mills, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>			
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>				ADDRESS <u>Reisterstown, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13375 CERTIFICATE OF DEATH 13378

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barbersville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Belinda</u> Middle <u>Irene</u> Last <u>Allen</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1967</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/57</u>	9. AGE (In years last birthday) <u>10</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elem. School</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Melvin K. Allen</u>					
14. MOTHER'S MAIDEN NAME <u>Melissa Peterson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Father Chart</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & cardiac</u> <u>1939</u> (b) <u>Arrest due to intracranial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>medulloblastoma & metastases (?)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>9-23</u> , 19 <u>67</u> , to <u>Oct 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 4</u> , 19 <u>67</u> , and that death occurred at <u>6:35</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Josefina A. de Castro</u>		22b. DATE SIGNED <u>10/4/67</u>		22c. PHYSICIAN'S NAME (Type) <u>MA. JOSEFINA A. DE CASTRO</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns Ann Calmar Mason Md</u>	23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>Donald J. Donaldson</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
26. ADDRESS <u>Donald J. Donaldson</u>		27. DATE <u>OCT 10 1967</u>					



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13376

CERTIFICATE OF DEATH

13379

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. LENGTH OF STAY in 1b <u>52 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Hall Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lydia Adole Harmony</u>		4. DATE OF DEATH <u>OCT. 5</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Md.</u>
13. FATHER'S NAME <u>John Thomas Almon</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Shane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-14-7900</u>	
17. INFORMANT <u>Mrs. Margaret Cameron</u>		Address <u>White Hall, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 C.I.C.V. disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>64</u> , to <u>10/5/67</u> , 19____, that (I) (we) last saw the deceased alive on <u>10/4</u> 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. M. France</u>		22b. DATE SIGNED <u>10/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. M. FRANCE</u>		22d. ADDRESS <u>PRAETON, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>Oct. 7 1967</u>	<u>Vernon Cemetery</u>	<u>White Hall, Md.</u>
24. FUNERAL DIRECTOR <u>Isaac Parteneston</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>OCT 9 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13371

13380

1 PLACE OF DEATH a. CO.-NTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 10/16/67		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 4005 Ardley Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MICHAEL BABY BOY		4 DATE OF DEATH Month October		Day 15		Year 1967			
5. SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH September 12 1967		9 AGE (In years last birthday) 1 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b KIND OF BUSINESS OR INDUSTRY none		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John B. Amrhein				14. MOTHER'S MA-DEN NAME Anna M. Kuchta					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Father, above		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple malformations DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)			
21. I certify that (*) (this hospital) attended the deceased from September 12 1967 , to October 15 1967 , that (*) (we) last saw the deceased alive on October 15 1967 , and that death occurred at 4:45 AM , from causes and on the date stated above.									
22a SIGNATURE Reynaldo Orjuela - Gomez, M.D.				22b DATE SIGNED 10-15-67		22c PHYSICIAN'S NAME (Type) Reynaldo Orjuela - Gomez, M.D.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		10/16/67		Holy Redeemer Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				25a REC'D BY REGISTRAR OCT 17 1967		25b REGISTRAR'S SIGNATURE James J. Judge			
3331 Brehms Lane				DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

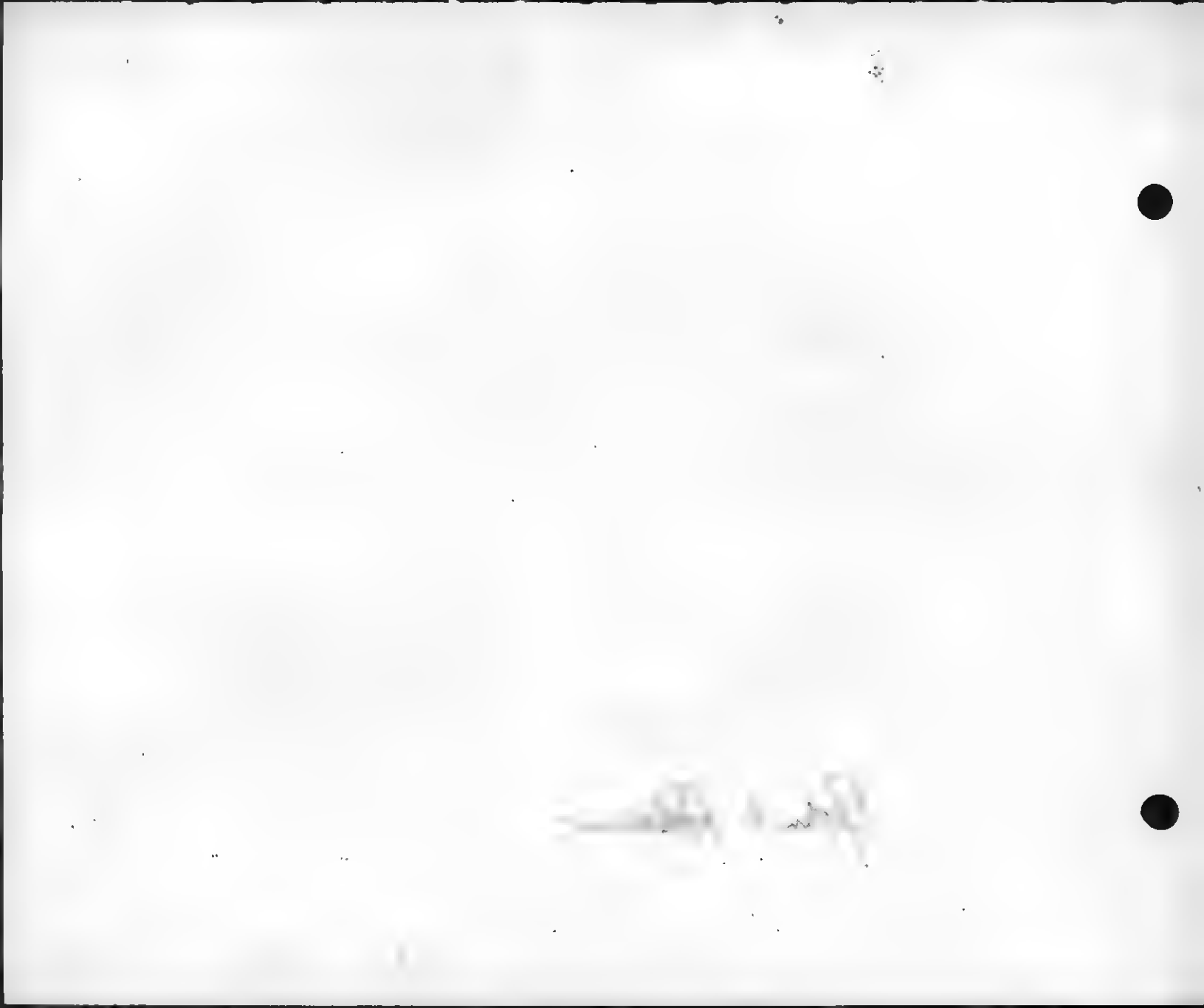


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12373					13381						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Baltimore					b. COUNTY MD.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO.						
c. LENGTH OF STAY IN 1b 1 day					d. STREET ADDRESS 118 W. 25th ST.						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Charles			Walter			Anderson			10 31 19 67		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		White		WIDOWED		7/30/08		59 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR				10b. KIND OF BUSINESS OR INDUSTRY NEWS PAPERMAN		11. BIRTHPLACE (County & State, or foreign country) N.J.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ?						14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 053-05-7582		17. INFORMANT Patient's Chart			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolization DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 10/30 , 19 67 , to 10/31 , 19 67 , that (I) (we) last saw the deceased alive on 10/31 , 19 67 , and that death occurred at 12:55 M. from the causes and on the date stated above.											
22a. SIGNATURE John E. Adams						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/31/67			
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.						22d. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORY LOUPON PARK			23d. LOCATION (City, town or county) (State) BALTO MD.			
24. FUNERAL DIRECTOR Paul E. Charney						ADDRESS 3617 Chestnut Ave		25a. REC'D BY REGISTRAR NOV 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13379

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13382

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1271 Maple Ave.		d. STREET ADDRESS 1271 Maple Ave. 21227	
3 NAME OF DECEASED (Type or print) First Addie Middle J. Last Augsburger		4 DATE OF DEATH Month October Day 23 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 yrs.
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Foreman		14. MOTHER'S MAIDEN NAME Lottie MacAbee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17. INFORMANT Mrs. Isabel Neighoff, 1271 Maple Ave.		Address 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitastatic Carcinoma Glands DUE TO (b) Carcinoma of Right Kidney DUE TO (c) undet. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 23, 1967 to Oct. 23, 1967 that (I) (we) last saw the deceased alive on Oct 22 1967 , and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE A. Bradley Daugharthy		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy		22d. ADDRESS 1264 Francis Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/26/67	23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery	23d. LOCATION (City or town) (County) (State) Stevensville Kent Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR ACT 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

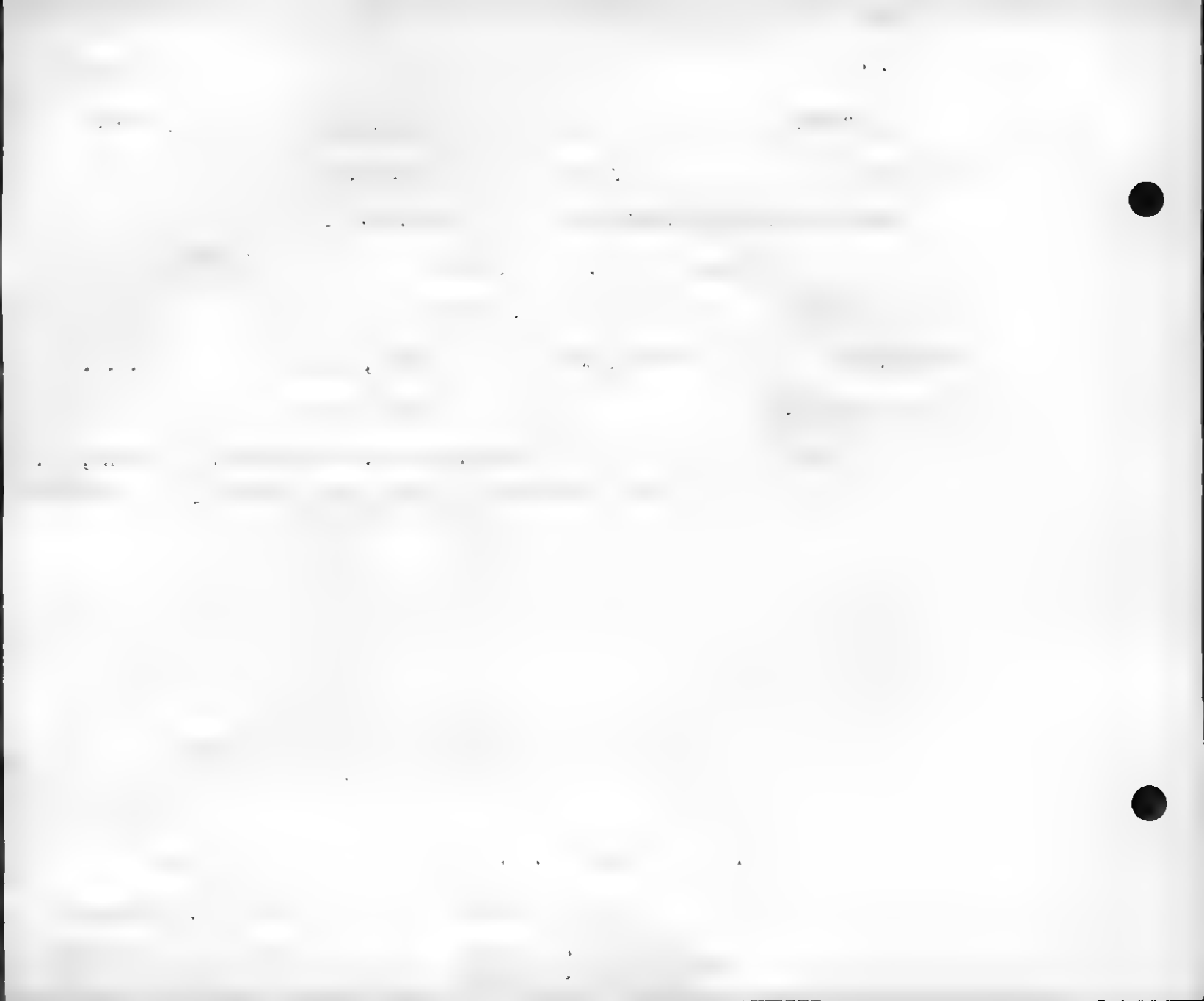


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
13383									
1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) QUANTICO				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					d. STREET ADDRESS RFD 1, Box 22			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First GEORGE Middle W. Last AUSTIN					4. DATE OF DEATH Month OCTOBER Day 19 Year 19 67				
5 SEX MALE		6 COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/16/18		9. AGE (In years lost birthday) yrs 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER			10b. KIND OF BUSINESS OR INDUSTRY TRUCKING COMPANY			11. BIRTHPLACE (County & State, or foreign country) QUANTICO, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM AUSTIN					14. MOTHER'S MAIDEN NAME SARAH CHURCH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 219 07 62 33		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM WITH WIDESPREAD METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from 10/6/67 , 19__, to 10/19/67 , 19__, that (X) (we) last saw the deceased alive on 10/19/67 , 19__, and that death occurred on 10/19/67 at 12:55AM from causes and on the date stated above									
22a. SIGNATURE <i>George C. McElpatrick</i> M.D.					22b. DATE SIGNED 10/19/67			22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/23/67		23c. NAME OF CEMETERY OR CREMATORY FAMILY CEMETERY			23d. LOCATION (City or Town) (County) (State) QUANTICO MARYLAND		
24. FUNERAL DIRECTOR <i>Clinton S. Stewart</i>					25a. REC'D BY REGISTRAR DATE OCT 25 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12381

CERTIFICATE OF DEATH

13384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b. COUNTY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c LENGTH OF STAY IN TB 6 DAYS		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d STREET ADDRESS 1525 POPALNO STREET		
3 NAME OF DECEASED (Type or print) First HARRY Middle STEPHEN Last BAKUN			4 DATE OF DEATH Month OCTOBER Day 6 Year 1967		
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/4/95	9 AGE (In years last birthday) 72 yrs.	F UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BURNER		10b KIND OF BUSINESS OR INDUSTRY U.S. COAST GUARD		11 BIRTHPLACE (County & State, or foreign country) RUSSIA	
13 FATHER'S NAME STEPHEN BAKUN			14 MOTHER'S MAIDEN NAME USTENA DULEVAR		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16 SOCIAL SECURITY NO 213 05 57 37		17 INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) PULMONARY EMPHYSEMA (c) MALNUTRITION DUE TO CARCINOMA OF ESOPHAGUS					INTERVAL BETWEEN ONSET AND DEATH MONTHS YEARS MONTHS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CYSTITIS, CHRONIC. DIABETES MELLITUS					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from SEPTEMBER 30, 1967 to OCTOBER 6, 1967 , that he (we) last saw the deceased alive on OCTOBER 6, 1967 , and that death occurred at 2:10 A.M. from causes and on the date stated above.					
22a SIGNATURE <i>George Dudas</i>			22b DATE SIGNED 10/6/67		
22c PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.			22d ADDRESS VAH FORT HOWARD, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF OCT. 9, 1967	23c NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY	23d LOCATION (City or Town) (County) (State) BALTO. Maryland		
24 FUNERAL DIRECTOR <i>Hahn</i> HAHN FUNERAL HOME		25a REC'D BY REGISTRAR DATE OCT 9 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

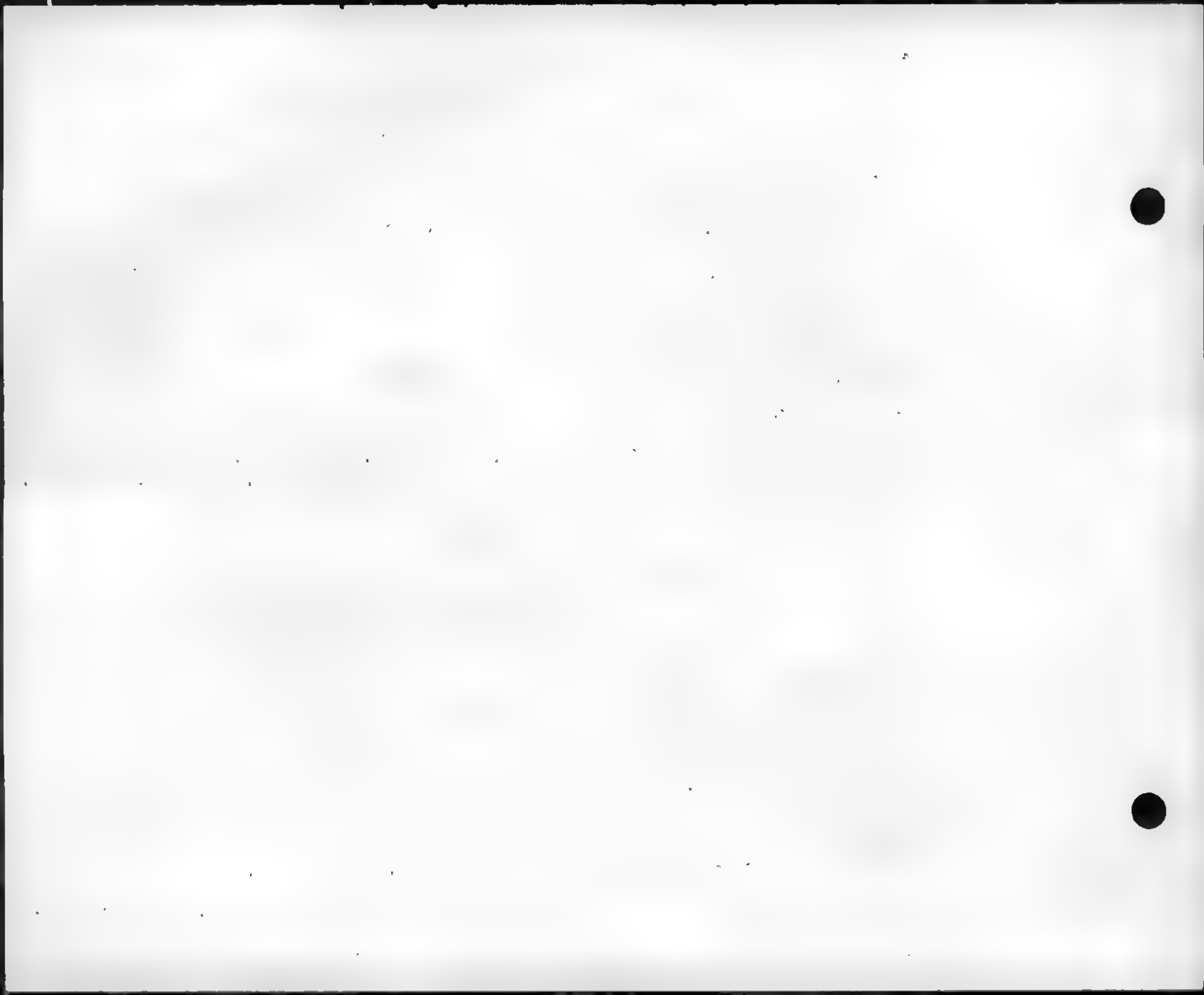
13382

CERTIFICATE OF DEATH

13385

1 PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Maryland b COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Lansdowne				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 219 Elizabeth Ave.				d. STREET ADDRESS Kingsville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Pearl Middle Eileen Last Bauer				4 DATE OF DEATH Month October Day 25 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/18	
9. AGE (In years last birthday) yrs. 49		10. UNDER 1 YEAR Months 1 Days 25		11. UNDER 24 HRS Hours 1 Min 0		12. C. T. ZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME - - - - Schultz				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles J. Bauer, Mt. Calvert Springs Motel, Rt. 1, Kingsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma DUE TO (c) Carcinoma of the Cervix Epidermoid							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 6/6/67 19____, and that death occurred at 12:45 AM, from causes and on the date stated above							
22a. SIGNATURE Marvin N. Sager				22b. DATE SIGNED 10/26/67		22c. PHYSICIAN'S NAME (Type) Marvin Sager	
22d. ADDRESS 3904 S. Hanover St.				22e. ADDRESS			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy. Arundel Md.	
24. FUNERAL DIRECTOR Hubbard Funeral Home, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE OCT 27 1967		25b. REGISTRAR'S SIGNATURE <i>Phillips, Judge</i>	

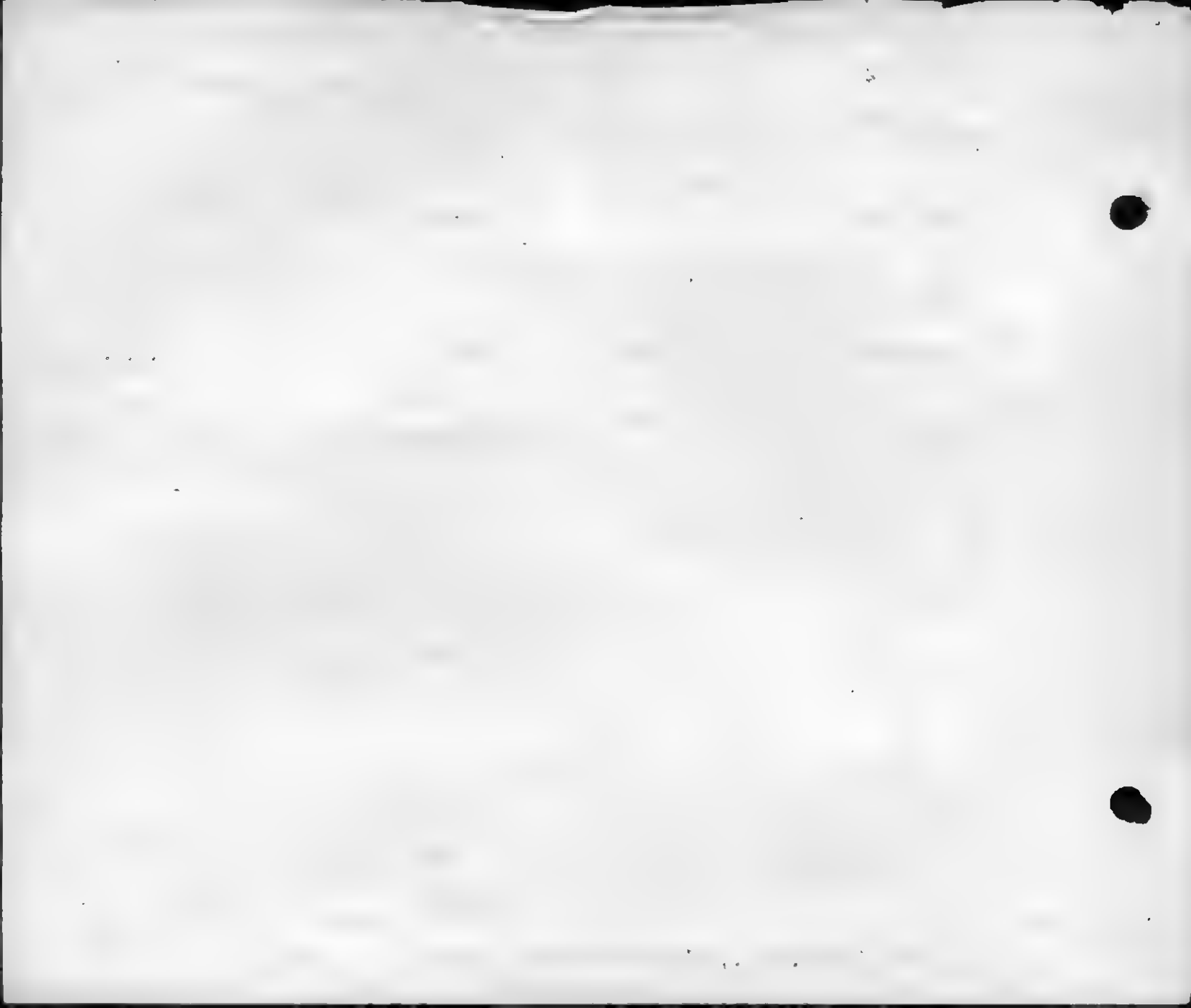
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
13383		13386	
1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
BALTIMORE COUNTY GENERAL HOSPITAL		3330 VIRGINIA AVENUE #21215	
3. NAME OF DECEASED (Type or print) Jennie Nmt Beerman		4. DATE OF DEATH 10 9 1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BAROL		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. BARNET BEERMAN, 3330 VIRGINIA AVE. #21215		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL Conditions, if any, which gave rise to immediate cause (b) Chronic Congestive Heart Failure (c) Arteriosclerotic Heart Disease DLE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 mos Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-29-67 to 10-9-67 , that (I) (we) last saw the deceased alive on 10-9-67 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Rolando A. Madamba		22b. DATE SIGNED 10-9-67	
22c. PHYSICIAN'S NAME (Type) ROLANDO A. MADAMBA		22d. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-11-67	
23c. NAME OF CEMETERY OR CREMATORY ANSHE EMLINAH AITZ CHAIN		23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC.		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13384

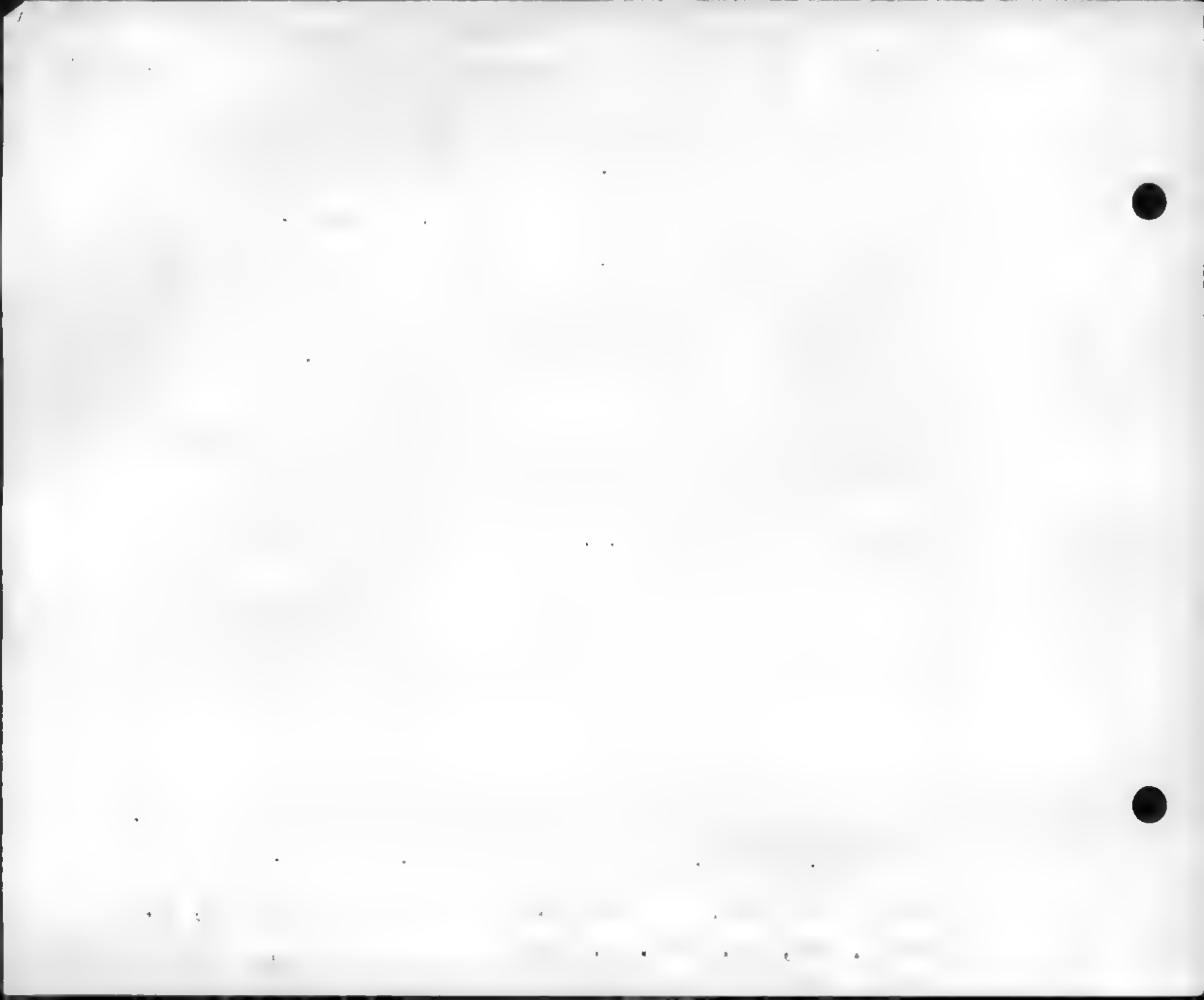
CERTIFICATE OF DEATH

13387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1yr. 5mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice		d. STREET ADDRESS 203 S. Dunstons Rd.	
3. NAME OF DECEASED (Type or print) First Emelma Middle M. Last Bell		4. DATE OF DEATH Month Oct. Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1883
9. AGE (In years, day, birthday) 83 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christian F. Richter		14. MOTHER'S MAIDEN NAME Mary Beck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220-090740	
17. INFORMANT Records of Stella Maris Hospice		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.D. DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 16 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 20:ay , 19 66 to Oct. 27 , 19 67 , that (I) (we) last saw the deceased alive on Oct. 27 , 19 67 , and that death occurred at 1:15p , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert J. Mahon</i>		22b. DATE SIGNED Oct. 27, 67	
22c. PHYSICIAN'S NAME (Type) R. J. MAHON, MD.		22d. ADDRESS 2 24, E. Joppa Rd.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 10/30/67.	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR OCT 31 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			



FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13388

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c LENGTH OF STAY IN 1b Hours	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Plant Dispensary		d STREET ADDRESS 1719 Melbourne Rd.	
3 NAME OF DECEASED (Type or print) First John Middle M Last Bent Sr.		4 DATE OF DEATH Month Oct. Day 17- Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-21-35
9 AGE (In years lost birthday) 32 yrs		10 UNDER 1 YEAR Months 32 Days 32 Hours 32 Min.	11 UNDER 24 HRS. Months 32 Days 32 Hours 32 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipfitter- Beth Steel Co.		10b KIND OF BUSINESS OR INDUSTRY Shipbldg.	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George Bent		14 MOTHER'S MAIDEN NAME Edna Lucas	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army 1952-1955		16 SOCIAL SECURITY NO 215-30-8843	
17 INFORMANT (Wife) Mrs. Carolyn Bent, 1719 Melbourne Rd.		Address Dundalk, Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushing injuries to entire Thorax and Pelvis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Stat.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck & run over by Straddle truck.	
20c TIME OF INJURY Month 10-17-67 Hour 8:05 AM 1967	20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Shipyard	20f (City or town) (County) (State) Sparrows Pt. Balto Co. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Morningside Rd. Dundalk, Md. 21222		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/20/67	
23c NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a REC'D BY REGISTRAR OCT 18 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 10-17-67	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12286

CERTIFICATE OF DEATH

13389

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c LENGTH OF STAY IN 1b <u>2 hr</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen Hosp.</u>		d STREET ADDRESS <u>8902 Middlebrook Ct</u>	
3 NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Berman</u> Last <u>Berman</u>		4 DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-03</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11 BIRTHPLACE (County & State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HILLEL ABRAMS</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO <u>220-18-8266</u>		17 INFORMANT Address <u>MR. BENJAMIN BERMAN, 8902 MIDDLEBROOK CT.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prob. Ac. Myocardial Infarction</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diabetic Acidosis</u> (c) <u>8 hr?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hr?</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Uremia</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>Oct 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-2</u> 19 <u>67</u> , and that death occurred at <u>4:15</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Daniel Bakal</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DANIEL BAKAL</u>		22d. ADDRESS <u>3600 Lochearn Dr 21207</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24 FUNERAL DIRECTOR ADDRESS <u>SDL LEVIVSON & BROS. INC. 6010 REISTERSTOWN RD.</u>		25. REC'D BY REGISTRAR <u>OCT 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13387 Item #2c & d Film #0334 12/6/67 ph

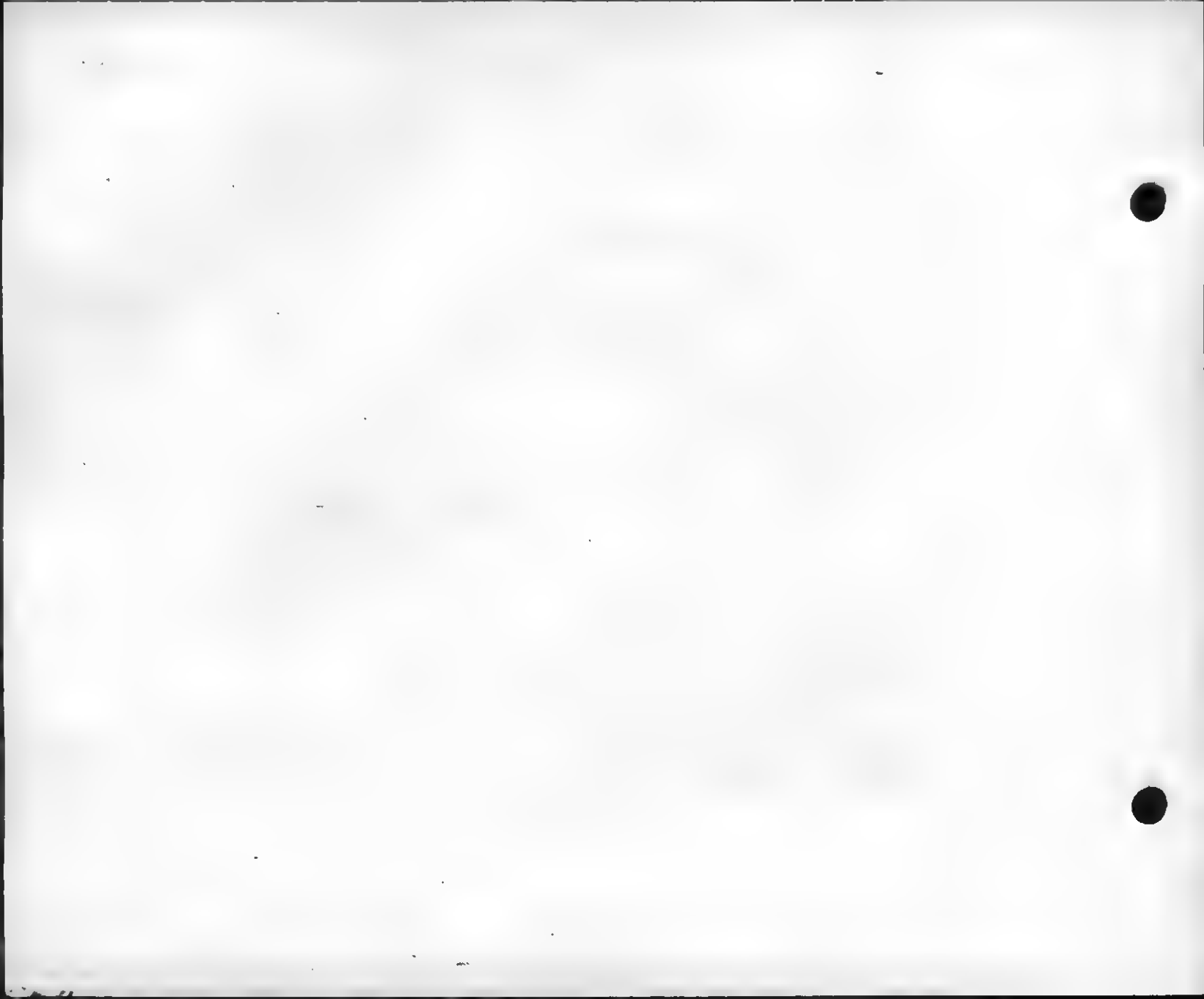
CERTIFICATE OF DEATH

13390

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u> c. LENGTH OF STAY IN <u>SEVEN YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'tal, give street address) <u>MARYLAND MASONIC HOME, COCKEYSVILLE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO. CO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u> Balto. d. STREET ADDRESS <u>334 E. Lorraine Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MISS MATTIE T. BIDDISON</u>			4. DATE OF DEATH <u>OCTOBER 25 1967</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3, 1878</u>	9. AGE (In years lost birthday) <u>89</u> yrs	10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>			
13. FATHER'S NAME <u>ZACHARIAH MASON BIDDISON</u>			14. MOTHER'S MAIDEN NAME <u>ELIZABETH ALLEN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>215-03-7973A</u>		17. INFORMANT <u>Masonic Home, #1</u> Address <u>Same as</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 331X DUE TO (b) <u>Chronic Brain Syndrome</u> DUE TO (c) <u>Multiple ischemic ulcer feet.</u>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1965</u> , to <u>Oct 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 25, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>JAMSHID HAMED MD</u>			22b. DATE SIGNED <u>OCT 25, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED MD</u>		
22d. ADDRESS <u>MASONIC HOME</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>	<u>10-27-67</u>	<u>Landon Park</u>		<u>Balto. Md.</u>			
24. FUNERAL DIRECTOR <u>W. C. Cook Burial Town</u>		25a. REC'D BY REGISTRAR <u>1030 York Rd</u>		25b. REGISTRAR'S SIGNATURE <u>William C. Cook</u>			
		DATE <u>OCT 27 1967</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13388

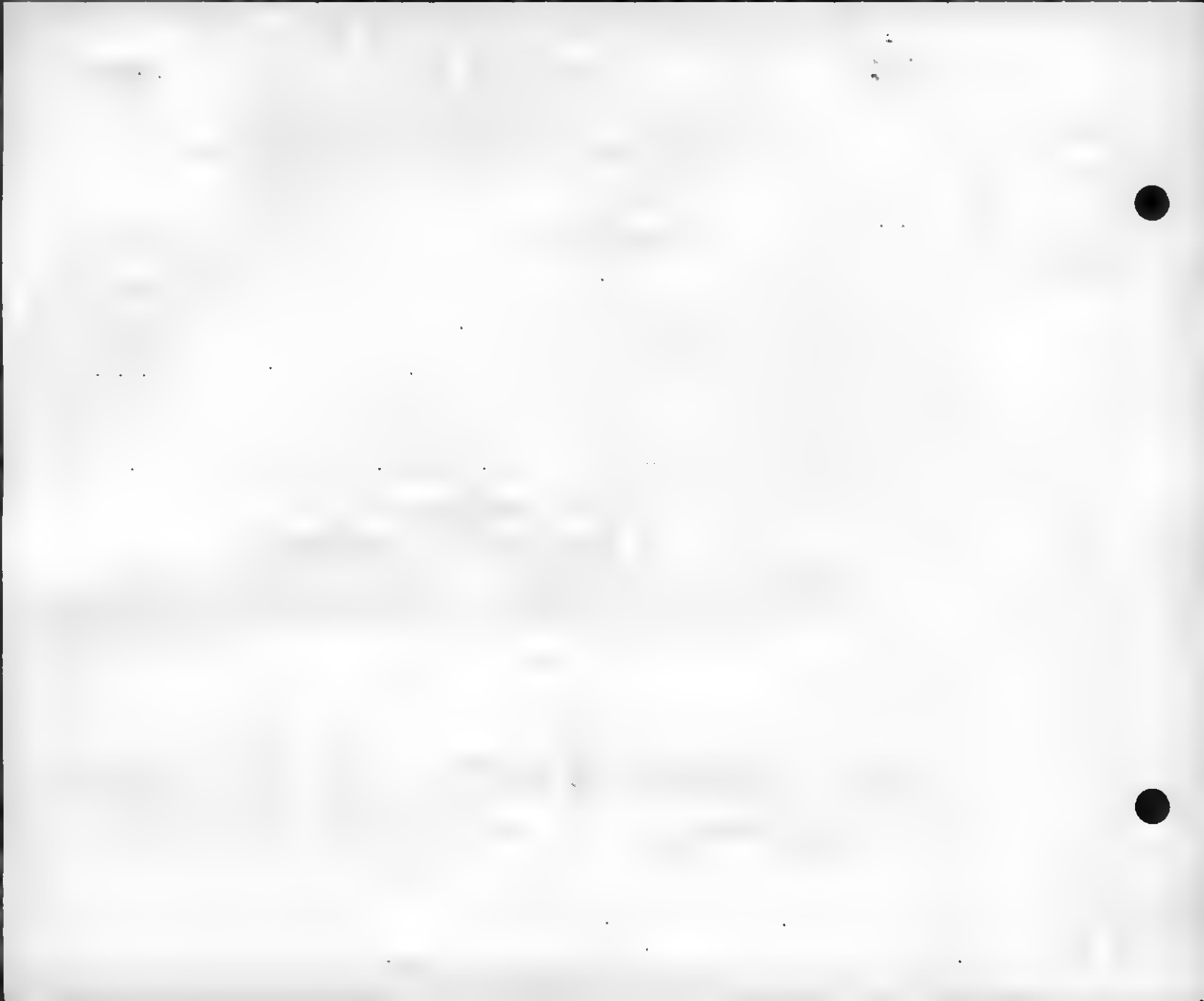
CERTIFICATE OF DEATH

13391

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b hrs		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville d. STREET ADDRESS 107 Dublin Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Randle Middle L. Last Biden		4. DATE OF DEATH Month October Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1896 9. AGE (In years lost birthday) 71 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Biden		14. MOTHER'S MAIDEN NAME Kate Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 048-03-8078	17. INFORMANT Mrs. Helen W. Biden Address 107 Dublin Dr. 21093
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aortic Stenosis DUE TO (b) C Myocardial Sclerosis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.C.V.D.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 64 to Oct 13, 1967 , that (I) (we) last saw the deceased alive on Oct 13, 1967 , and that death occurred at 2:00 M, from causes and on the date stated above.			
22a. SIGNATURE C. M. B. Byrd		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) AT Paul Byrd Jr		22d. ADDRESS 5820 York Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR DET 18 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13389

13392

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u> c. LENGTH OF STAY IN b <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4316 SPENCER ST</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u> d. STREET ADDRESS <u>4316 SPENCER ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH</u> <u>BLACKWELL</u>		4. DATE OF DEATH Month Day Year <u>10</u> <u>25</u> <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3-5-1908</u>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CATERIA WORKER</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>DEPT. STONE F/ERTON Co Ga</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>JANE BURTON</u>			14. MOTHER'S MAIDEN NAME <u>LIZZIE OGBORN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>OTIS BLACKWELL</u>		17. INFORMANT <u>4316 SPENCER ST</u> <u>HALETHORPE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio-vascular disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above							
22a. SIGNATURE <u>[Signature]</u>			22b. DATE SIGNED M.D. _____		22c. PHYSICIAN'S NAME (Type) <u>THORNTON T. FULLER M.D.</u>		
22d. ADDRESS <u>1249 N. Fuller Ave</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				
23b. DATE THEREOF <u>10/27/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARABUTUS MEM PR</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD 21227</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13393

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD - TAYLOR		c. LENGTH OF STAY N 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A. P. STORE			d. STREET ADDRESS 6914 Belair Road		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
3. NAME OF DECEASED (Type or print) L EARL BLAKISTONE			4. DATE OF DEATH OCT 16 1967		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1893	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of year, or even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Heusler Printing Company		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.	
13. FATHER'S NAME Herbert Blakistone			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO W 1		17. INFORMANT Emma Mc Cubbins	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4301 MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 10-16-67	
EXAMINER'S NAME (Type) William A. Pillsbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE THEREOF 10-17-67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City or Town)		(County)		(State)	
Baltimore, Maryland-21206		Baltimore, Maryland-21206		Baltimore, Maryland-21206	
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE McDonald, Judge
DATE OCT 23 1967					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13391

13391

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville 21093 d. STREET ADDRESS 251 Meadowvale Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Seibert D. BOLLINGER		4. DATE OF DEATH Month October Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager Seagram		10b. KIND OF BUSINESS OR INDUSTRY Distillers	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bollinger		14. MOTHER'S MAIDEN NAME Barbara Peeling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes. WW1		16. SOCIAL SECURITY NO. 216-10-9379	
17. INFORMANT Mrs. Mayme L. Bollinger		Address 251 Medowvalle, Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cardio respiratory arrest DUE TO (b) Cerebro vascular hemorrhage DUE TO (c) Generalized arteriosclerosis.			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/1/ , 19 67 , to 10/2/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/2/ , 19 67 , and that death occurred at 7:40M. from causes and on the date stated above.			
22a. SIGNATURE <i>Beatriz P. Dizon</i> M.D.		22b. DATE SIGNED October 2, 1967	
22c. PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/5/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Parkville, Md.
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR DATE OCT 5 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



13392

CERTIFICATE OF DEATH

13395

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALL TOWN</u>		c. LENGTH OF STAY IN TB <u>3 1/2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp.</u>		d. STREET ADDRESS <u>2401 EUTAW PLACE</u>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>JANIE</u> <u>Middle</u> <u>—</u> <u>Last</u> <u>BONN</u>		4. DATE OF DEATH <u>Month</u> <u>10</u> <u>Day</u> <u>24</u> <u>Year</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-79</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Rode</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET McAllister</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-55190</u>	
17. INFORMANT <u>Hosp. Record</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> DUE TO (b) <u>ARTERIOSCLEROTIC H. DISEASE</u> DUE TO (c) <u>ATHEROSCLEROSIS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>GANGRENE OF RT FOOT</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-20-1967</u> , to <u>10-24-1967</u> , that (I) (we) last saw the deceased alive on <u>10-24-1967</u> , and that death occurred at <u>6 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Rolando A. Madamba</u> M.D.		22b. DATE SIGNED <u>10-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MADAMBA MD</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR <u>ULLIRICH FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ACT 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far back papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

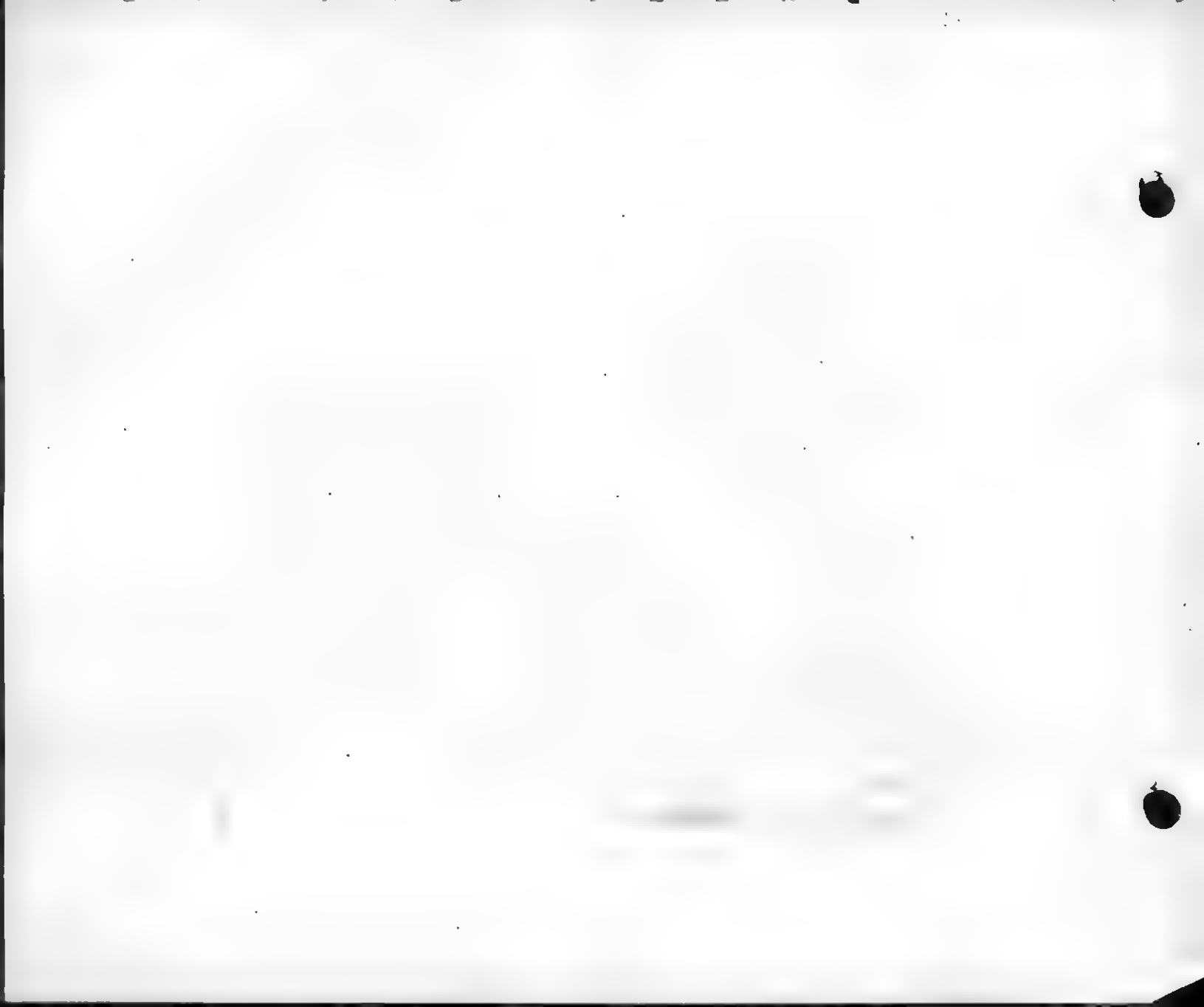
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13396

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middlesex			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS 957 ARNCLIFFE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilson Middle C Last Boone				4. DATE OF DEATH Month October Day 20 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-10	9. AGE (in years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 57 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSEMAN		10b. KIND OF BUSINESS OR INDUSTRY REA EXPRESS		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Boone				14. MOTHER'S MAIDEN NAME ANNA D. TAYLOR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212-01-8130		17. INFORMANT ETTA M. BOONE ARNCLIFFER Address 957			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of body of the pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/4 , 19 67 , to 10/20 , 19 67 , that (I) (we) last saw the deceased alive on 10/20 , 19 67 , and that death occurred at 5:25M , from the causes and on the date stated above.							
22a. SIGNATURE John E. Adams				P. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.				22d. ADDRESS 6701 N. Charles Street, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-24-67		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY		23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR Philip L. Crach		ADDRESS 1211 Chesapeake		25a. REC'D BY REGISTRAR 11-2-67		25b. REGISTRAR'S SIGNATURE Richard S. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filled with page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

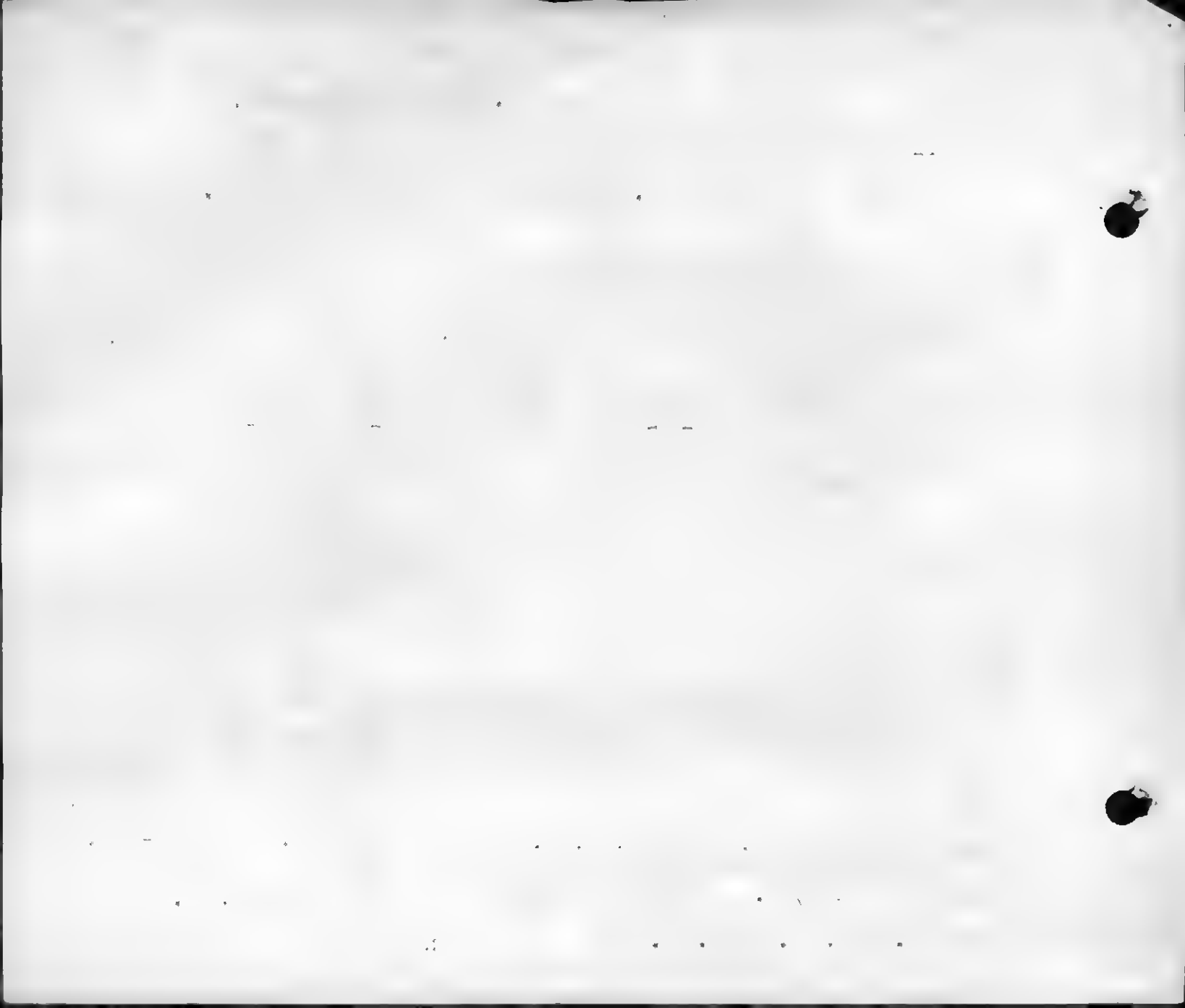
100294

CERTIFICATE OF DEATH

13397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MD. 9000 Carlisle Ave. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--- Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21236	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION xxx 9001 Carlisle Ave.		d. STREET ADDRESS 9001 Carlisle Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Myrtle Middle May Last Bowers		4. DATE OF DEATH Month October Day 29 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1895
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY York, Penna	
11. BIRTHPLACE (State or foreign country) York, Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Norris		14. MOTHER'S MAIDEN NAME Mary Emma Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO 215-01-4178D	
17. INFORMANT Louise Bowers-Daughter-in-law		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoptysis-due to possible peptic ulcer 2, 3 X DUE TO Multiple myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
INTERVAL BETWEEN ONSET AND DEATH 5 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Spring , 1966 , to October , 1967 , that I last saw the deceased alive on Oct, 10, 1967 , and that death occurred at 12:35 pm from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9660 Belair Rd. Balto 36- Md. DATE SIGNED 10-30-67			
ACTUAL SIGNATURE Barbara A. Solomon M.D.			
PHYSICIAN'S NAME (Type) Barbara A. Solomon, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/67.	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rack, Inc. Balto. Md. 21214		24a. REC'D BY REGISTRAR DATE NOV 1 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

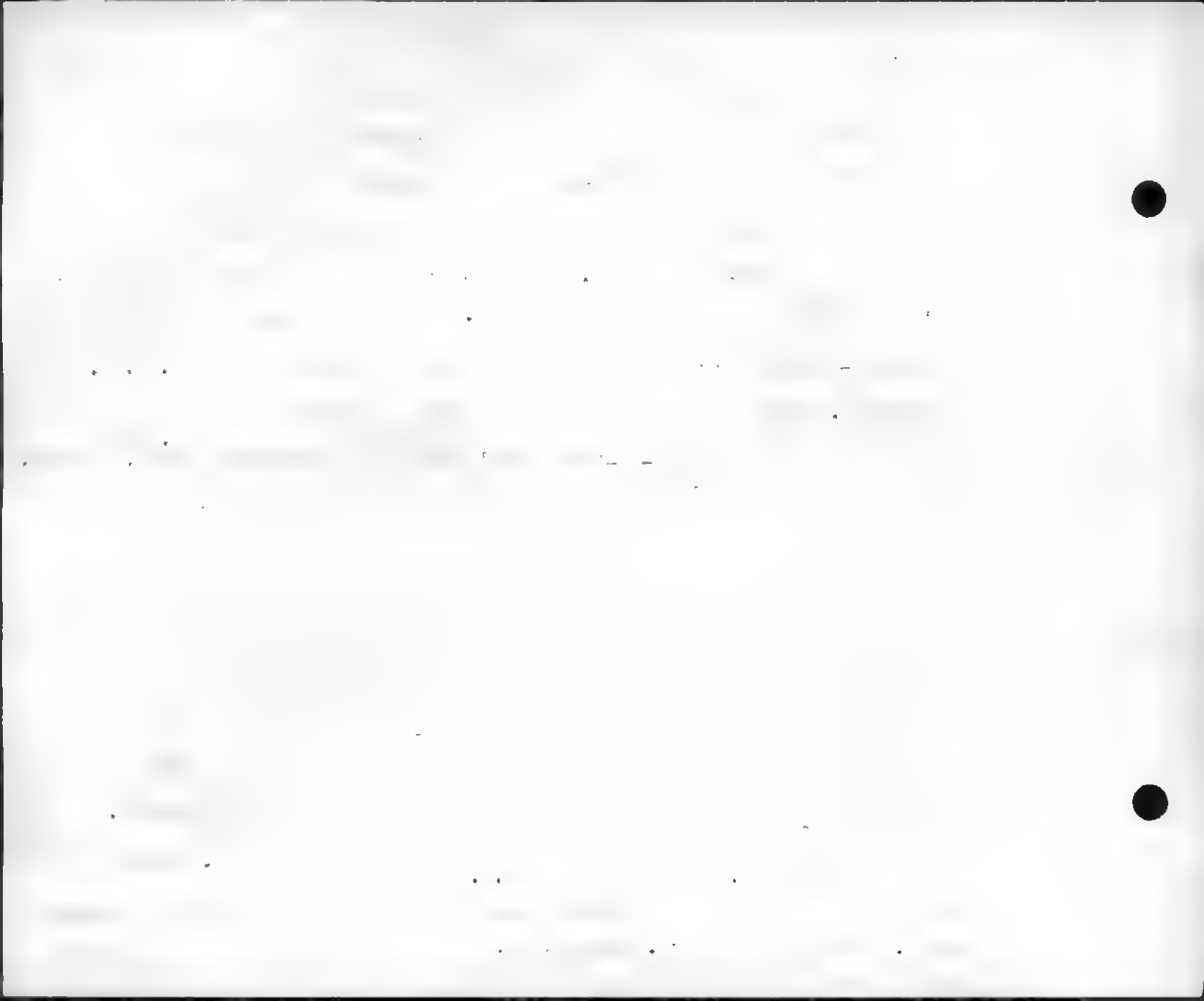
13398

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2634 Liberty Parkway		d. STREET ADDRESS 2634 Liberty Parkway	
3 NAME OF DECEASED (Type or print) First Middle Last Rosa K. Bowers		4. DATE OF DEATH Month Day Year October 4, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 11, 1886
9 AGE (In years last birthday) 80 yrs		FUND 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Office Work		10b. K AND OF BUSINESS OR INDUSTRY West Virginia	
11 BIRTHPLACE (State or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME William F. Bowers		14. MOTHER'S MAIDEN NAME Amelia Schleilb	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16 SOCIAL SECURITY NO 213-54-1767	
17 INFORMANT (Brother) Carl Bowers, 2634 Liberty Parkway, Dundalk,		Address Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year hour am p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theodore C. Patterson EXAMINER'S NAME (Type) Theodore C. Patterson		M.D. M.D.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR ACT 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 10/5/67	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



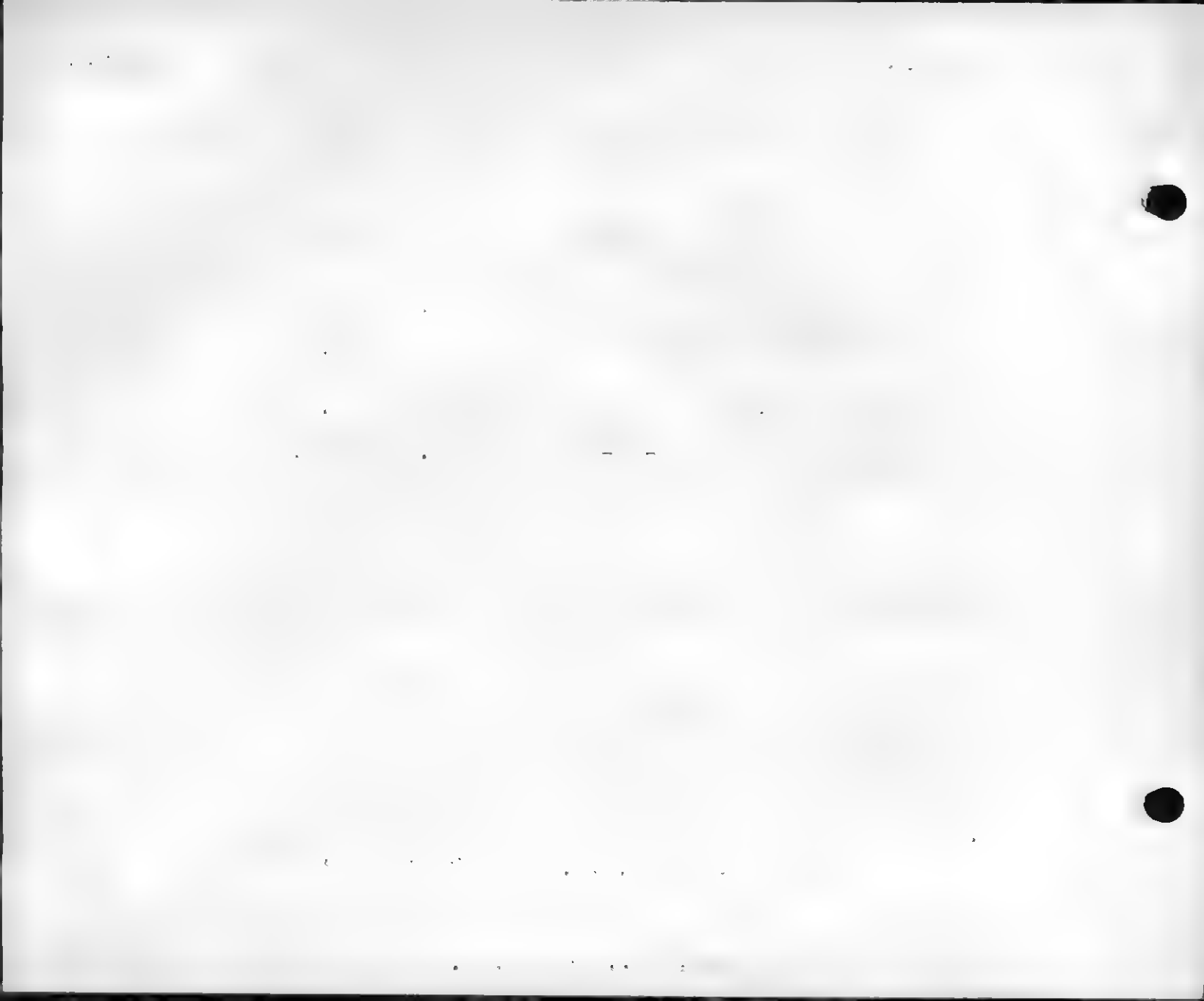
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13399									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 50 Township Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 50 Township Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN FRANCIS BRADLEY					4. DATE OF DEATH Month October Day 23rd Year 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1888		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Bradley					14. MOTHER'S MAIDEN NAME Harriet M. Horrell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. 213-07-4555		17. INFORMANT Address Mary M. Bradley, same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Papillary									INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Melvin B. Davis					22. DATE SIGNED 10/25/67				
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Dundalk, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md.					25a. REC'D BY REGISTRAR OCT 26 1967				
					25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

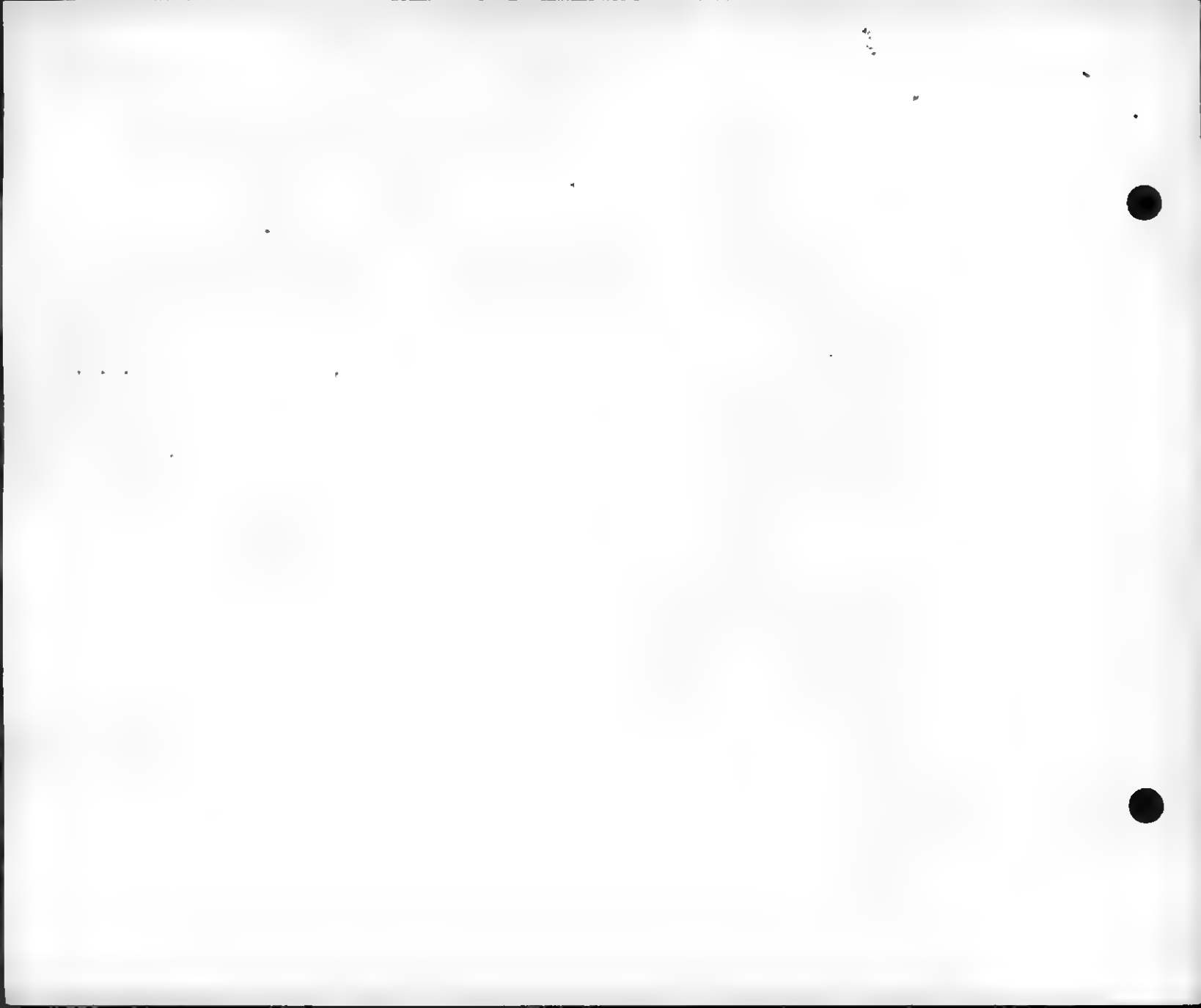
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13297

13400

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. STREET ADDRESS 12301 Branfield Ct. #13	
3. NAME OF DECEASED (Type or print) David Patrick Bradshaw		4 DATE OF DEATH Month 10 Day 11 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-7-60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reuben Joesph Bradshaw		14. MOTHER'S MAIDEN NAME Winifred Guthrie	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO none	
17 INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute hemorrhagic Necrosis, Bilateral Adrenal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Meningococcal Septecemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State) 8:45 PM.	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5 Dec , 1966 to 10 - 11 , 1967 that (I) (we) last saw the deceased alive on 11 Oct 1967, and that death occurred at 8:45 PM , from causes and on the date stated above.			
22a SIGNATURE Richard A. Jones		22b DATE SIGNED 12 Oct 67	
22c PHYSICIAN'S NAME (Type) Richard A. Jones		22d ADDRESS Rosewood State Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10-13-67	
23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR OCT 16 1967	
		25b REGISTRAR'S SIGNATURE William J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

BP

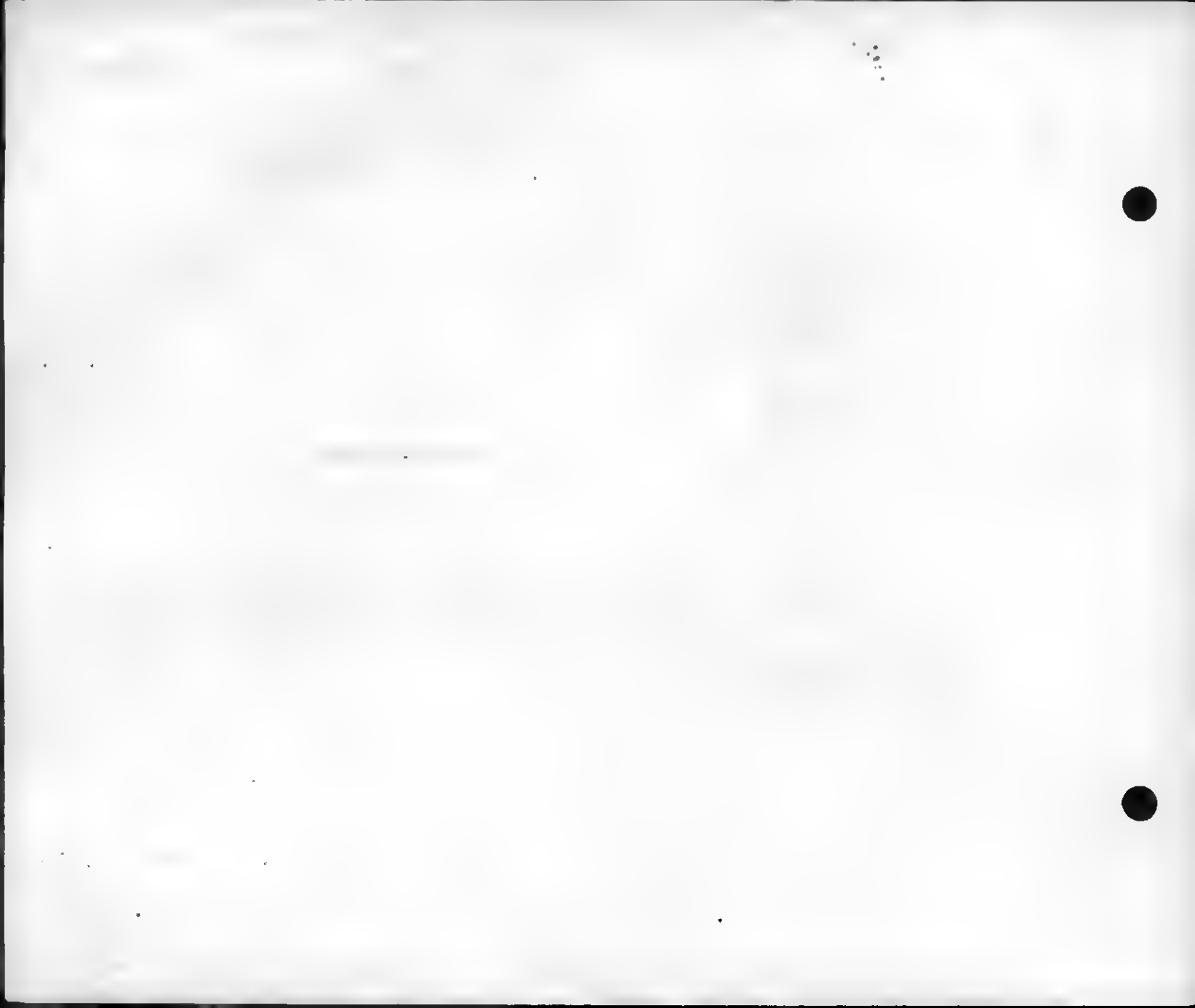
13293

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13401

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN b 23 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Larry Middle Miller Last BRADY		4. DATE OF DEATH Month 10 Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-38
9. AGE (in years last birthday) yrs 29		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		11b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Prince Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Owen Brady		14. MOTHER'S MAIDEN NAME Hazel Marie King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bilateral Nectotizing Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 wks. (c) 3 wks.		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 9/18 , 19 44 , to 10/30 , 19 67 , that he (we) last saw the deceased alive on 10/30 , 19 67 , and that death occurred at 9:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones, M.D.		22b. DATE SIGNED 10-31-67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 Nov. 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md. AA	
24. FUNERAL DIRECTOR Donald Baker		25. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE William C. Jones		25c. REGISTRAR'S NAME William C. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

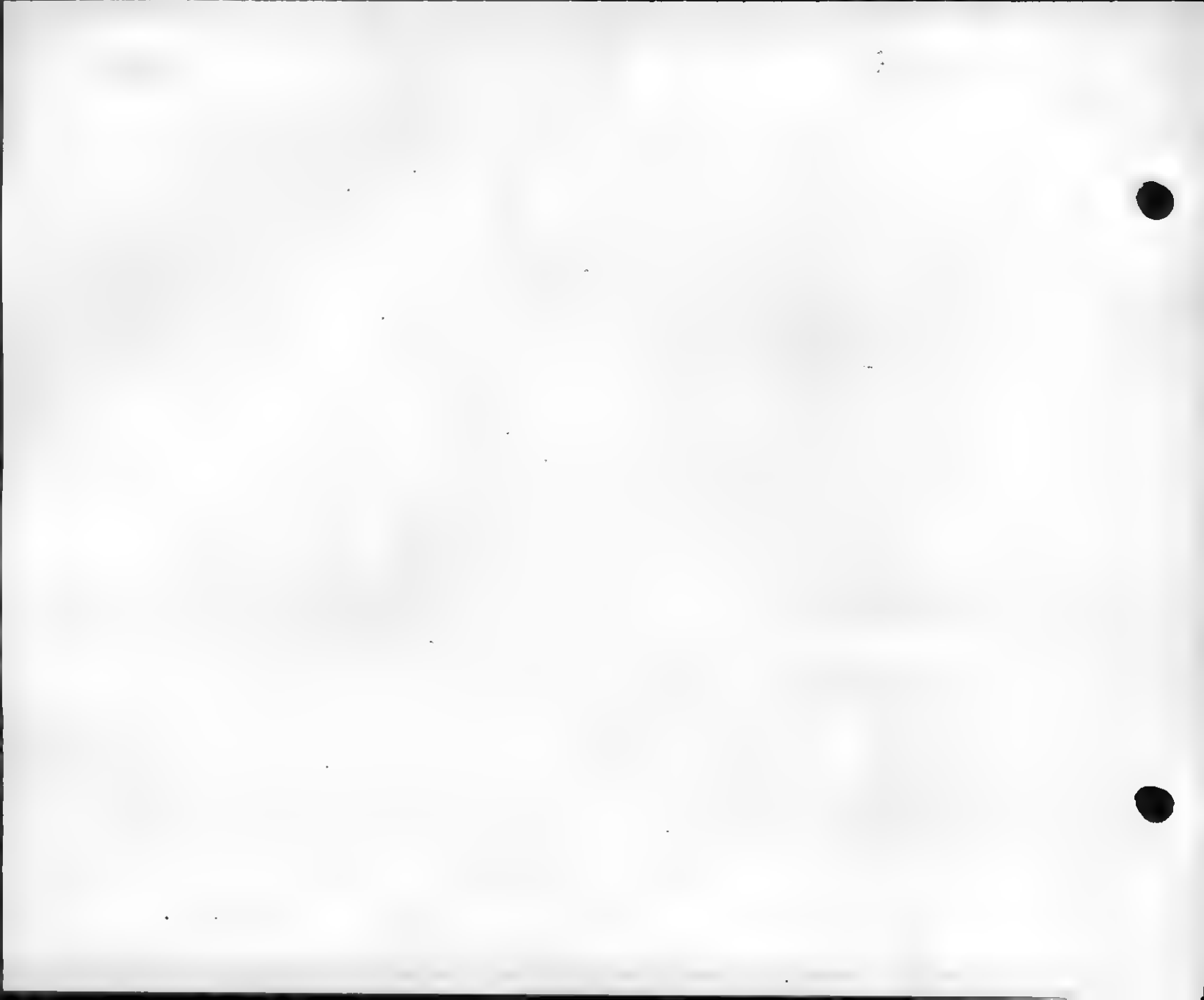
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13399

CERTIFICATE OF DEATH

13402

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u> City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXX Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 Mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>			d. STREET ADDRESS <u>1417 Carswell Rd (18)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>Harry W. Brengle</u>			4. DATE OF DEATH Month Day Year <u>Oct 31 1967</u>		
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/17/29</u>	9 AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>19 67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager - Hotel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, md</u>	
13. FATHER'S NAME <u>William Brengle</u>			14. MOTHER'S MAIDEN NAME <u>W. K.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>W. K.</u>		16 SOCIAL SECURITY NO. <u>216-32-7107</u>		17 INFORMANT <u>A. J. P. Chast</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>/</u> DUE TO (c) <u>/</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>/</u>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>/</u>		20f. (City or town) (County) (State) <u>/</u>
21. I certify that (I) (this hospital) attended the deceased from <u>8/21/1967</u> to <u>10/31/1967</u> that (I) (we) last saw the deceased alive on <u>10/31/1967</u> , and that death occurred at <u>7:00 PM</u> , from causes and on the date stated above					
22a. SIGNATURE <u>David E. Zickatsoose</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/31/67</u>
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickatsoose</u>			22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. Fickert Sons</u> Address <u>Balto, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>NOV 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

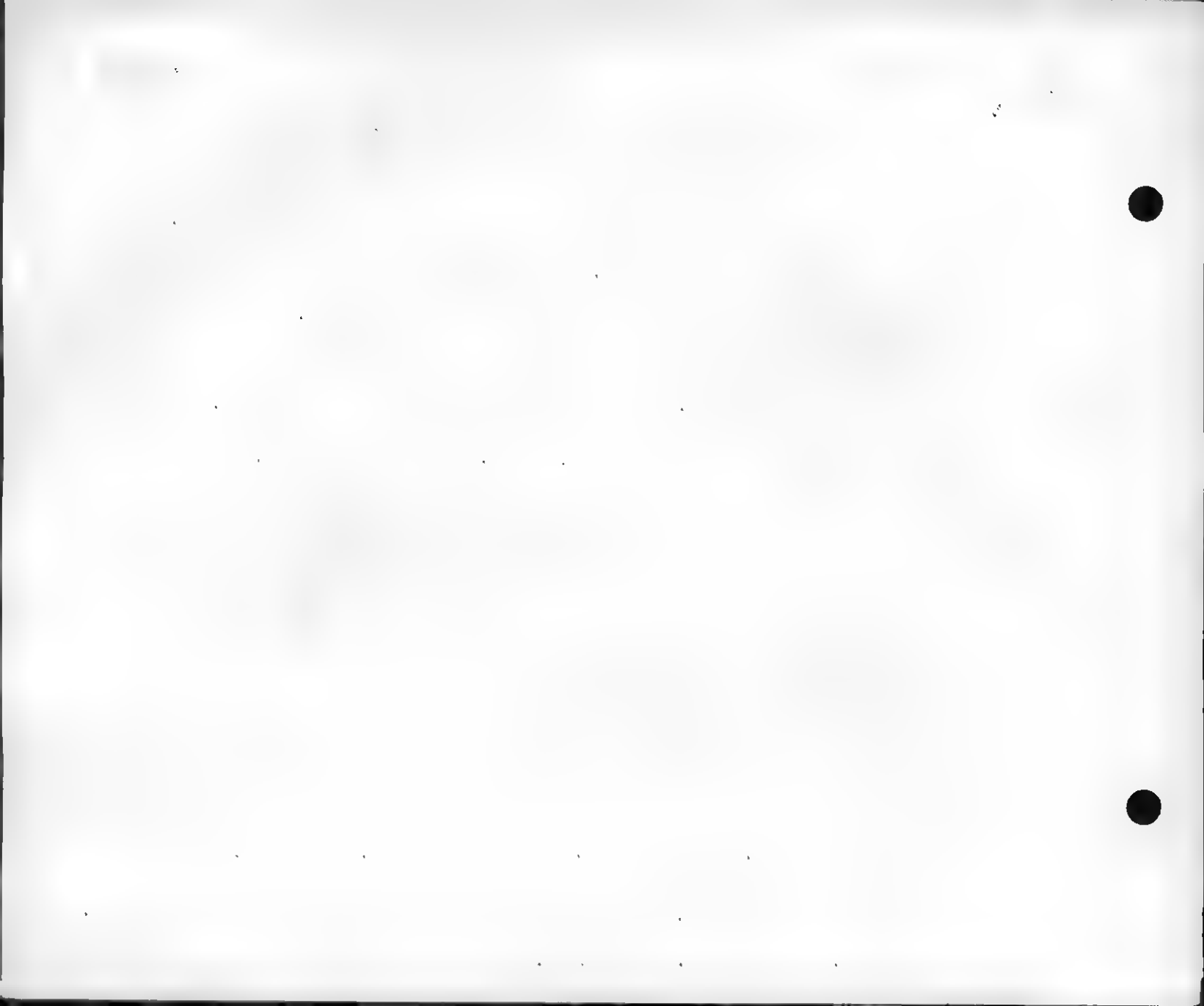
13400

13403

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>				d. STREET ADDRESS <u>3825 Belair Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William E. Brennan</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 19, 1904</u>		9. AGE (In years lost birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric</u>		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas J. Brennan</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Becker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-5300</u>		17. INFORMANT Address <u>Mr. William Turner, 1209 Gleneagle Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> + 2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Generalized arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>6 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>10-13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-5</u> 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Frank E. Leslie</u>				22b. DATE SIGNED <u>10-13-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Frank E. Leslie M.D.</u>	
22d. ADDRESS <u>302 C. 3rd St.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13404

13401

1. PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN It 10 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT NURSING HOME				d STREET ADDRESS ROCK SPRINGS			
3 NAME OF DECEASED (Type or print) First Middle Last CELESTE W. BRENTANO				4 DATE OF DEATH Month Day Year OCTOBER 21 19 67			
5 SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unk 1883	9 AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George WELLS				14. MOTHER'S MAIDEN NAME Anna Lenhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT CHART Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE HEAD OF THE DUE TO PANCREAS, WITH WIDE SPREAD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTASIS. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/11 , 19 67 , to 10/21 , 19 67 ; that (I) (we) last saw the deceased alive on 10/14 , 19 67 , and that death occurred at 6:40 AM , from causes and on the date stated above							
22a. SIGNATURE E. Kasa				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) E. KASAITIS, M.D.				22d. ADDRESS 1801 FREDERICK RD, BALTIMORE MD 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks West Inc. Balt. Md. 21228				25a. REC'D BY REGISTRAR DATE OCT 25 1967		25b. REGISTRAR'S SIGNATURE Charles J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

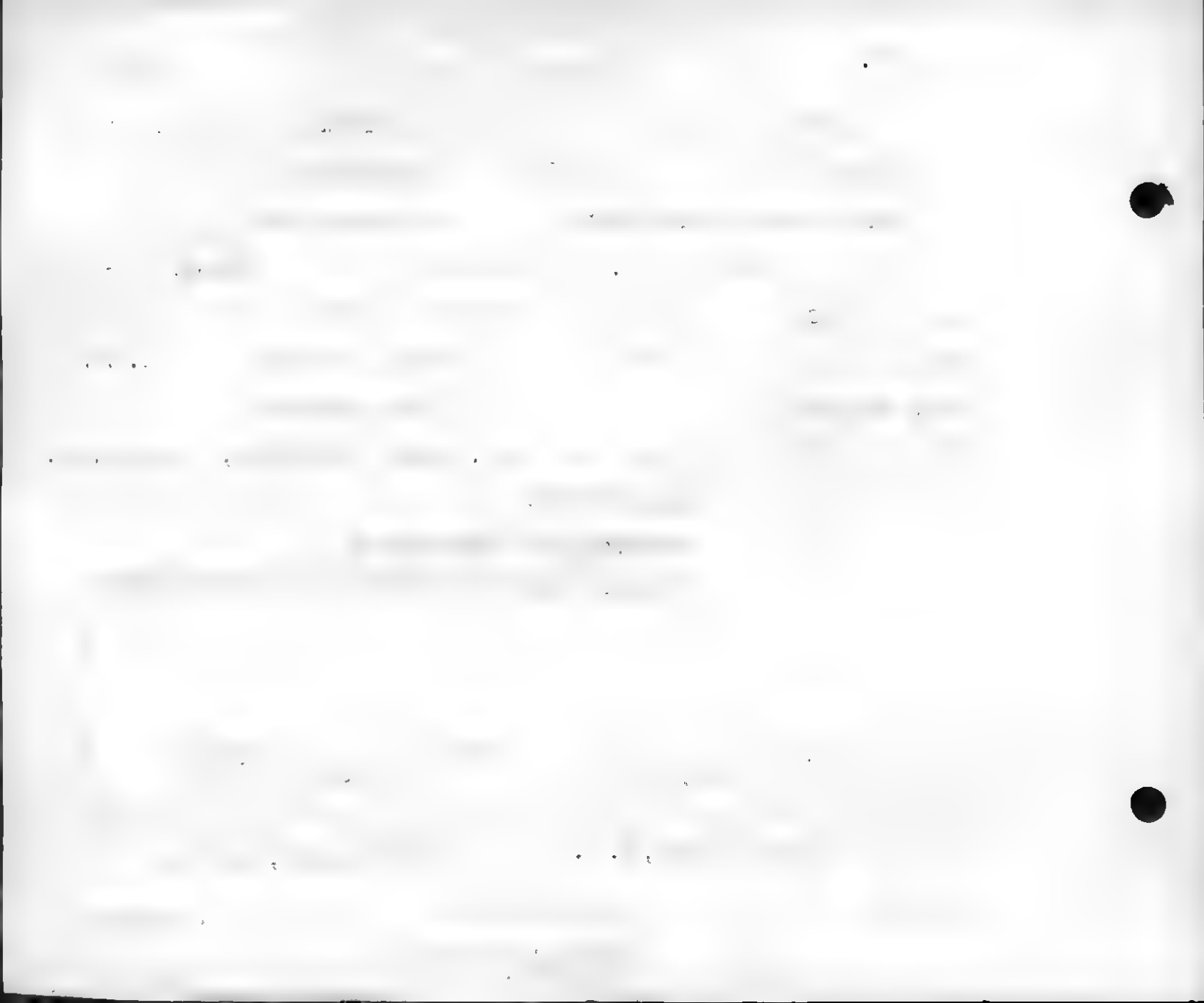
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13402

CERTIFICATE OF DEATH

13405

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 217 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) REISTERSTOWN	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d STREET ADDRESS 222 HIGHMEADOW ROAD		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First HENRY Middle V. Last BRILLHART			4. DATE OF DEATH Month OCTOBER Day 3 Year 19 67		
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH SEPTEMBER 1, 1891	9 AGE (In years last birthday) 76 yrs	10 UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b KIND OF BUSINESS OR INDUSTRY BREWERY		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME EDWARD BRILLHART			14 MOTHER'S MAIDEN NAME ELIZA KLIENFELTER		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO 217 05 21 45		17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) THROMBOSIS CEREBRAL ARTERIES DUE TO ARTERIOSCLEROSIS					INTERVAL BETWEEN ONSET AND DEATH RECENT
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 2/28/67 , 19__, to 10/3/67 , 19__, that (X) (we) last saw the deceased alive on 10/3/67 , 19__, and that death occurred at 6:00A M, from causes and on the date stated above.					
22a SIGNATURE <i>Jorge A. Fabara</i>			M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/3/67
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.			22d ADDRESS VAH FORT HOWARD, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF Oct. 6, 1967	23c NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>H. J. Schhardt</i>		ADDRESS ECKHARDT FUNERAL HOME		25a REC'D BY REGISTRAR OCT 5 1967	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>
		REISTERSTOWN, MARYLAND			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

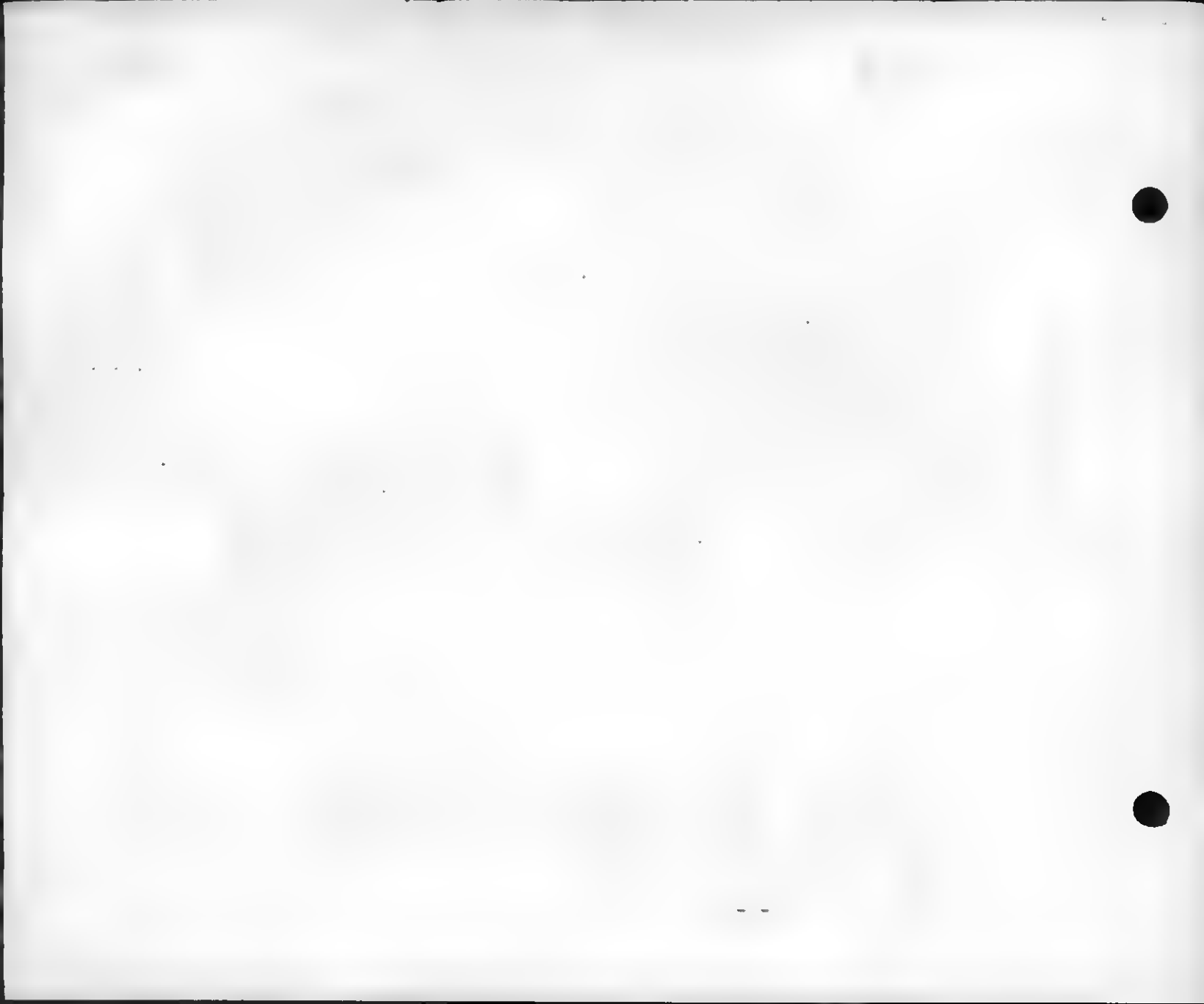
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13407

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTIMORE COUNTY GENERAL HOSPITAL		d. STREET ADDRESS 3104 MINNA COURT #21207	
3. NAME OF DECEASED (Type or print) First RUBIN Middle R. Last BROOKS		4. DATE OF DEATH Month OCTOBER Day 3 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTALLATION		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	11. BIRTHPLACE (County & State, or foreign country) NEW YORK
13. FATHER'S NAME CHARLES BROOKS		14. MOTHER'S MAIDEN NAME SHANE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	
17. INFORMANT MRS. RENA BROOKS, 3104 MINNA CT., #21207		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE - PREVIOUS MYOCARD. INFARCT 1962 DUE TO (c) 1962			INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV. 1966 , to 10-3-1967 , that (I) (we) last saw the deceased alive on FEB 1966 , and that death occurred at 11:30 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Joseph Deckelbaum M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-3-67
22c. PHYSICIAN'S NAME (Type) DR. JOSEPH DECKELBAUM		22d. ADDRESS 3502 W. ROGERS AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 110-8-67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.		25a. REC'D BY REGISTRAR OCT 11 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



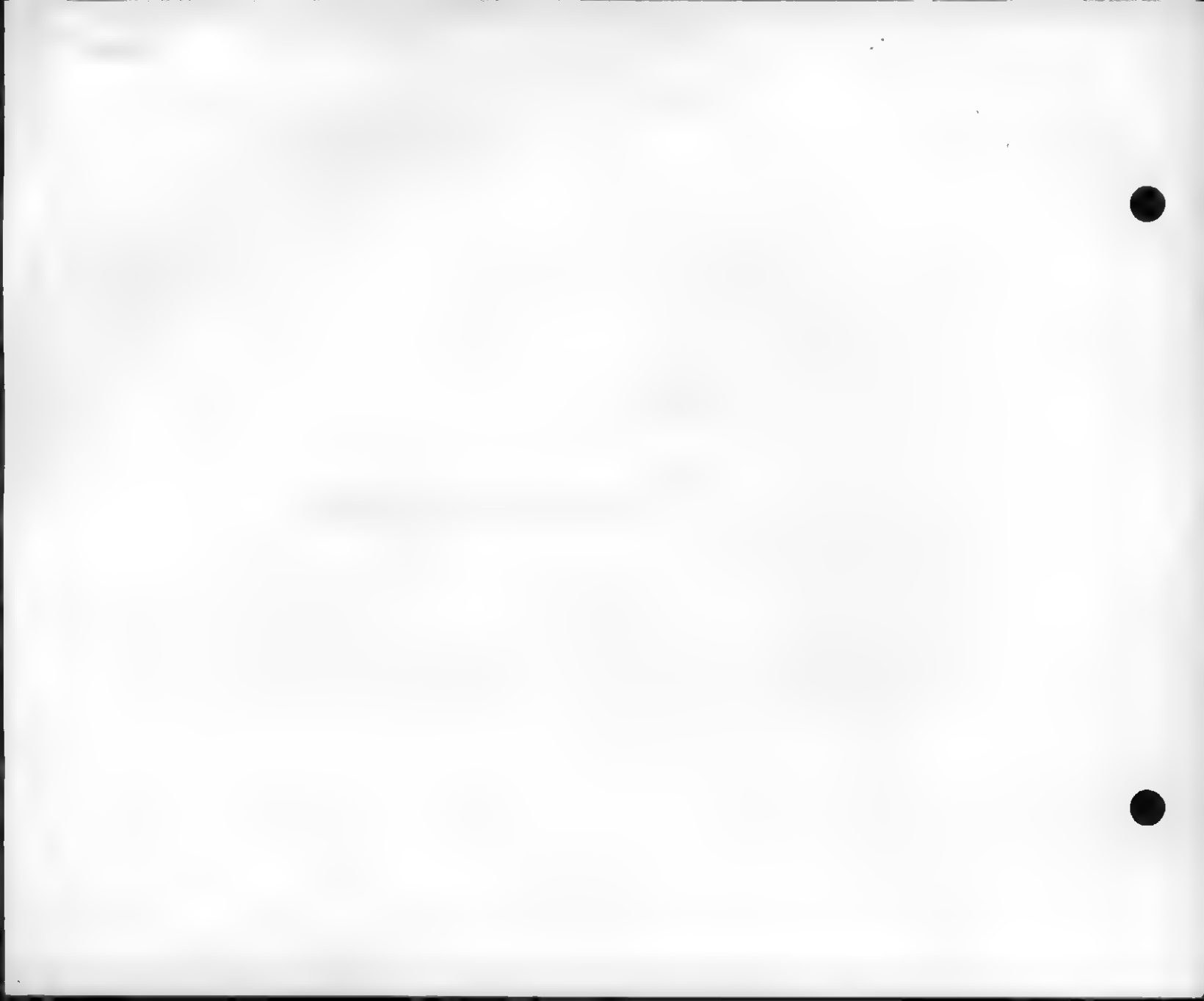
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13408

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTO. MEDICAL CENTRE</u>		d. STREET ADDRESS <u>708 ALLENDALE ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH C. BROWN</u>		4. DATE OF DEATH Month Day Year <u>OCTOBER 21 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-30</u>
9. AGE (in years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIE WEST CLEMENTS</u>		14. MOTHER'S MAIDEN NAME <u>SELBY (ROBERTA)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-20-3412</u>	
17. INFORMANT <u>MR. SAMUEL BROWN</u>		Address <u>708 ALLENDALE ST</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 18, 1967</u> , to <u>Oct. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21, 1967</u> , and that death occurred at <u>9:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Marjorie S. Fike</u>		22b. DATE SIGNED <u>Oct. 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERSTACIA E. FABIE</u>		22d. ADDRESS <u>Greater Baltimore Med. Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARbutus Memorial PK</u>	23d. LOCATION (City or Town) (County) (State) <u>ARbutus BALTO Co, MD</u>
24. FUNERAL DIRECTOR <u>HERBERT E. NUTTEN</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Yuanes J. J...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY in 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS Shady Oaks Trailer Court	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First HARRY Middle MILTON Last BURLESON		4 DATE OF DEATH Month 10 / Day 26 / Year 1967	
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1909
9 AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 5 Days 8 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		10b. KIND OF BUSINESS OR INDUSTRY Electric	
11 BIRTHPLACE (County & State, or foreign country) Mitcher Co., N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Asa Burleson		14. MOTHER'S MAIDEN NAME Judie Greene	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 245-05-9176	
17. INFORMANT Records at Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculosis (c) Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Bronchitis, Pulmonary Emphysema		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/23/1967 to 10/26/1967 , that (I) (we) last saw the deceased alive on 10/26/1967 , and that death occurred at 5:00 PM , from causes and on the date stated above.			
22a. SIGNATURE William Newcomer		22b. DATE SIGNED 10-26-1967	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-67	
23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery		23d. LOCATION (City or town) (County) (State) Spring Pine NC	
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis MD.		25a. REC'D BY REGISTRAR OCT 31 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13406

13410

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall, Maryland</u>	
c. LENGTH OF STAY in 1b <u>42 days</u>		d. STREET ADDRESS <u>Greater Balt. Med. Center</u>	
e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Eliza</u> Last <u>Burns</u>		4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-04</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, MD.</u>		12. CIT ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Almon (De.)</u>		14. MOTHER'S MAIDEN NAME <u>MAYS (Priscilla Rutledge)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-8284</u>	
17. INFORMANT <u>Admission Sheet</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>2021</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) <u>① OF EVER, UNKNOWN ETIOLOGY</u> (c) <u>② SPLENOMEGALY, UNKNOWN ETIOLOGY</u> DUE TO (d) <u>③ POSSIBLE LYMPHOMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ANEMIA AND ELECTROLYTE IMBALANCE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 7, 1967</u> to <u>OCT. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT. 18, 1967</u> , and that death occurred at <u>8:17 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Manuel A. Gongon</u>		22b. DATE SIGNED <u>Oct. 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. MANUEL A. GONGON</u>		22d. ADDRESS <u>GBMC, TOWSON, MD 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vulcan Valley Mem. Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Towson, Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>L. Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u> </u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

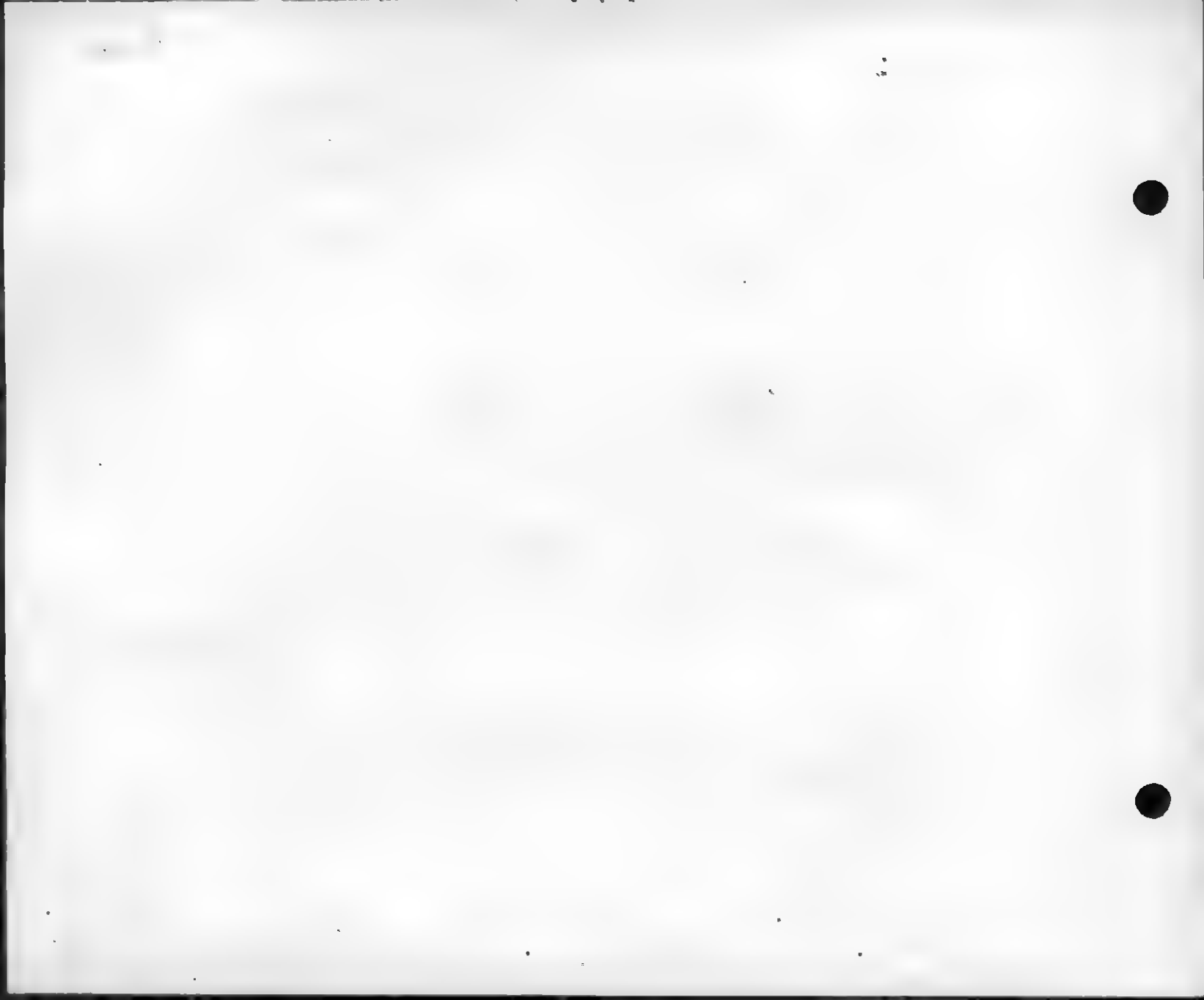
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13407

CERTIFICATE OF DEATH

13411

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL c. LENGTH OF STAY IN 1b 3 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VILLA MARIA - NOTCH - CLIFF		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS GLEN-ARM e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) SISTER MARY JOSIA BYRNE		4. DATE OF DEATH Month 10 Day 8 Year 1967	
5 SEX F.	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY CONVENT	9. AGE (In years lost birthday) 71 yes
11 BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PATRICK BYRNE		14. MOTHER'S MAIDEN NAME MARY ANNE QUAIL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 220-54-2925-T	
17. INFORMANT SR. CATHERINE MARY		Address Glen-Arm Notch Cliff	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Severe Anemia DUE TO (c) Aplastic Bone Marrow Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 10/5 , 19 67 , and that death occurred at 12:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Henry L. McConkie		22b. DATE SIGNED 10-12-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Sisters Cemetery	23d. LOCATION (City or Town) (County) (State) Glen Arm Balt. Md.
24. FUNERAL DIRECTOR Raymond J. Curran		25a. REC'D BY REGISTRAR Charles J. [Signature]	
ADDRESS 817 Scarlett Dr. Towson, Maryland 21204		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



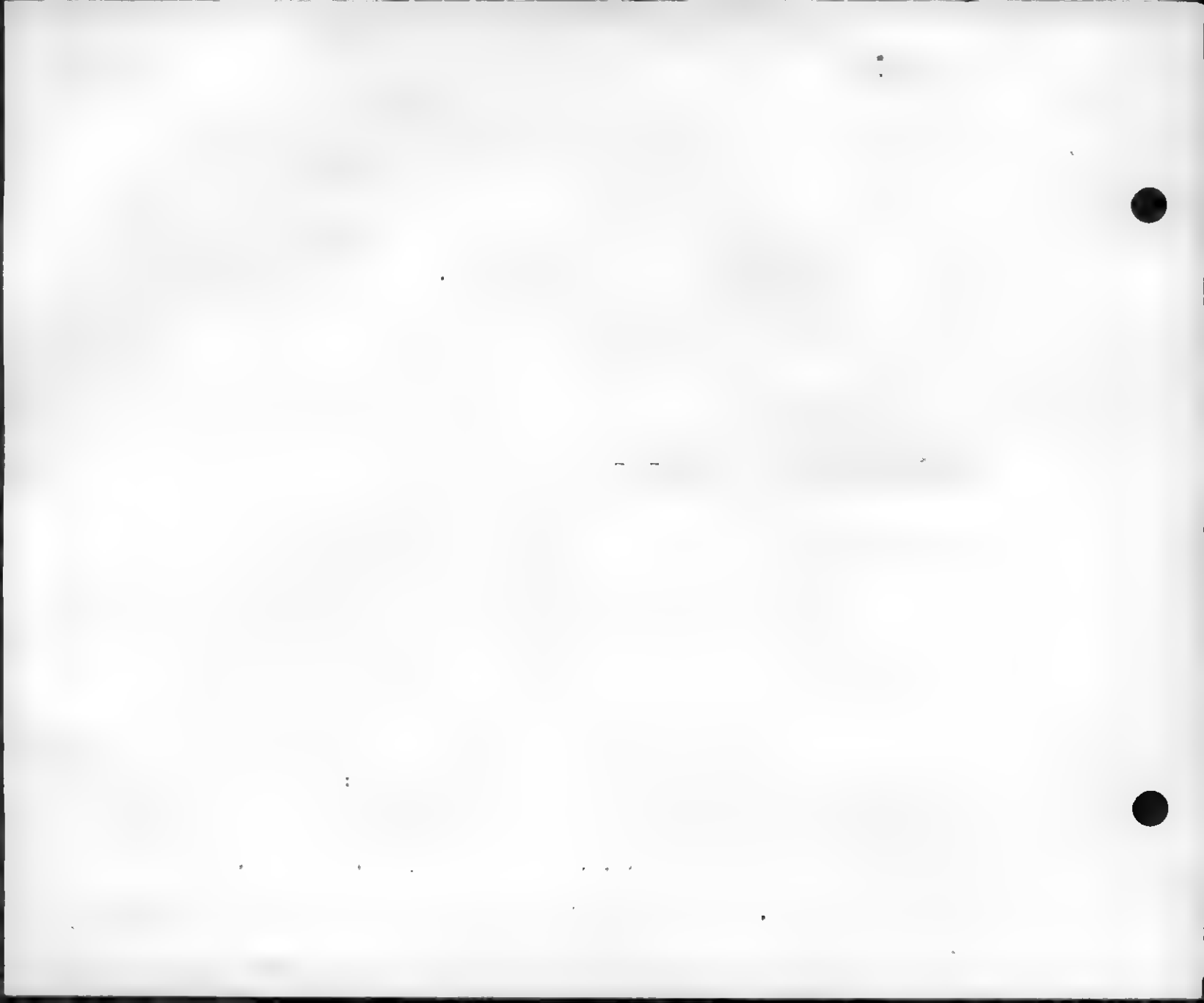
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13412

1. PLACE OF DEATH a. COUNTY Baltimore		b. STATE Md	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 8 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice		d. STREET ADDRESS 3612 Yolando Road	
3. NAME OF DECEASED (Type or print) First Middle Last Edward S. Carney, Sr.		4. DATE OF DEATH Month Day Year 10/23/67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/1880
9. AGE (in years lost birthday) 87 yrs		10. FUND 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab worker		10b. KIND OF BUSINESS OR INDUSTRY Factory	
11. BIRTHPLACE (County & State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Carney		14. MOTHER'S MAIDEN NAME Elizabeth Sweeney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO 216-07-7407	
17. INFORMANT Hospice records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CVA DUE TO (c) ASCVD			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/1/59 , 19__, to 10/23/67 , 19__, that (I) (we) last saw the deceased alive on 10/22/67 , 19__, and that death occurred at 2:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED 10/23/67	
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D.		22d. ADDRESS 204 E. Joppa Rd., Towson	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 25, 67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25a. REC'D BY REGISTRAR 1050 York Road Towson, Maryland 21204	
25b. REGISTRAR'S SIGNATURE OCT 25 1967		25c. REGISTRAR'S SIGNATURE John A. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO.		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD.		b. COUNTY BALTO.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ESSEX		d. STREET ADDRESS 14 TERRACE RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT R. CARRICK		4. DATE OF DEATH OCT. 19 1967		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 6, 1883		9. AGE (in years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK CARRICK		14. MOTHER'S MAIDEN NAME AMY HOOD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK.		16. SOCIAL SECURITY NO. 717-07-8355		17. INFORMANT EDITH CARRICK	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V DISEASE DUE TO SENILITY Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE M.B. DAVIS		EXAMINER'S NAME (Type) M.B. DAVIS		6800 MORNINGTON RD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10/19/67			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/23/67		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART		22d. LOCATION (City, town, or county) BALTO. MD.		23. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		24a. REC'D BY REGISTRAR OCT 21 1967		24b. REGISTRAR'S SIGNATURE Malvinas Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

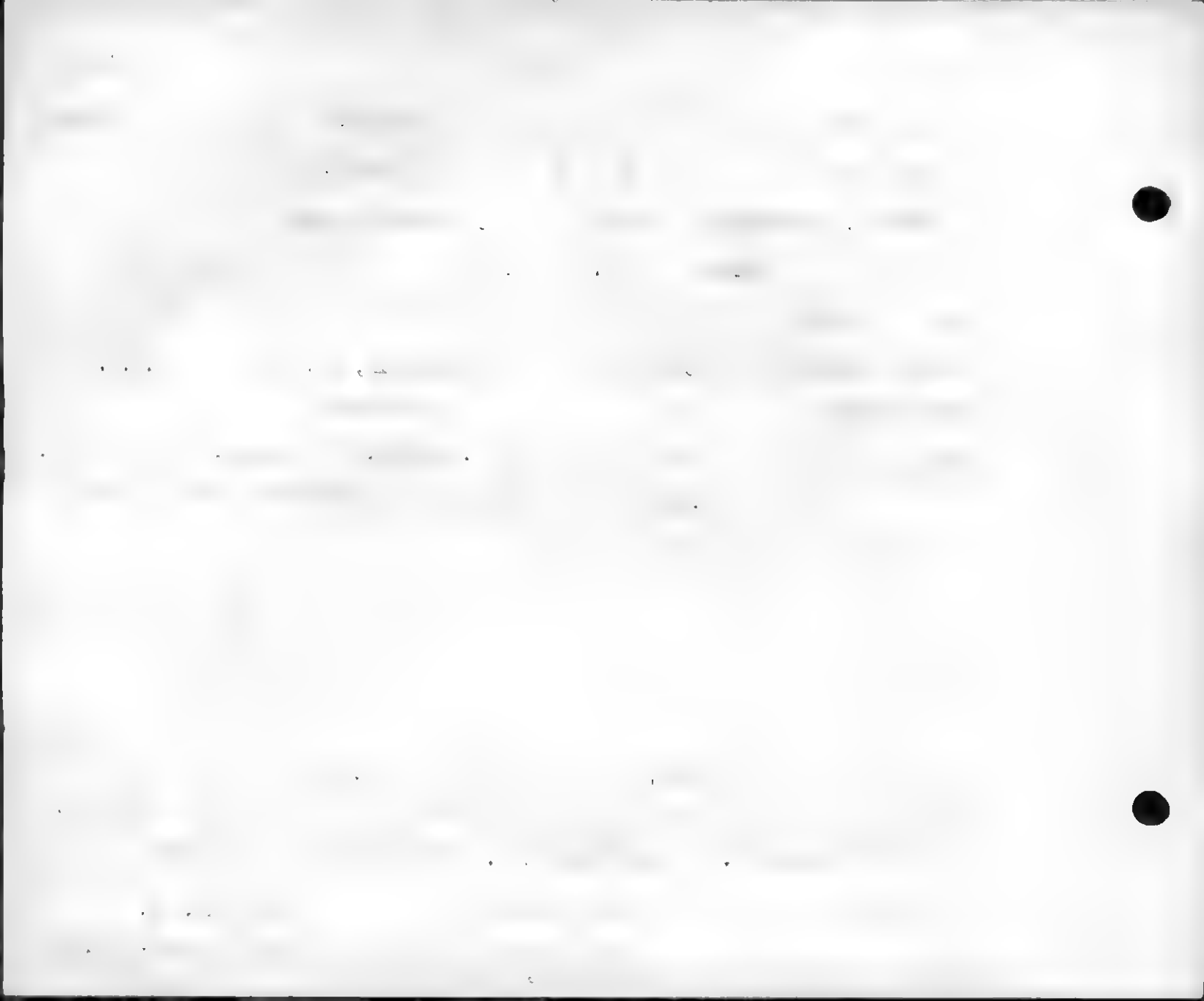
CERTIFICATE OF DEATH

13414

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN IT 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS d. STREET ADDRESS 57 CALVERT STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle B. Last CARROLL		4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/21/06
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KITCHEN HELPER		10b. KIND OF BUSINESS OR INDUSTRY COLLEGE	11. BIRTHPLACE (County & State or foreign country) ANNAPOLIS, MARYLAND
13. FATHER'S NAME JAMES CARROLL		14. MOTHER'S MAIDEN NAME IRENE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 214 14 33 23	17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA, METASTATIC OF NECK 1919 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN DEATH MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 9/25/67 , 19 to 10/18/67 , 19, that (we) last saw the deceased alive on 10/18/67 , 19, and that death occurred at 6:00A M, from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick M.D.</i>		22b. DATE SIGNED 10/18/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-23-1967	23c. NAME OF CEMETERY OR CREMATORY BURELL CEMETERY	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS, MD.
24. FUNERAL DIRECTOR <i>William Reese #</i>		25a. REC'D BY REGISTRAR OCT 19 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13411

CERTIFICATE OF DEATH

13415

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Towson</u>		c LENGTH OF STAY IN 1b <u>5 wks 6 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix, Md. 21131</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d STREET ADDRESS <u>None listed</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Miles</u> Middle <u>R.</u> Last <u>Carroll, Sr</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-12-88</u>	9 AGE (In years lost birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Owner of Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harsford Co., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>J. Perry Carroll</u>				14. MOTHER'S MAIDEN NAME <u>Curry, Susannah.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-3349</u>		17 INFORMANT <u>Patient's Chart</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour : m. _____ p.m. _____ 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>8/27</u> , 19 <u>67</u> , to <u>10/7</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>10/7/67</u> , 19 <u>67</u> , and that death occurred at <u>9:35 AM</u> , from causes and on the date stated above							
22a SIGNATURE <u>Duncan McGhie</u>		22b DATE SIGNED <u>10/7/67</u>		22c PHYSICIAN'S NAME (Type) <u>DUNCAN MCGHIE</u>			
22d ADDRESS <u>5645, Lochain Rd. Balto Md</u>		22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>Oct. 10, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore County, Md</u>	
24. FUNERAL DIRECTOR <u>Wm Cook, Brooks Towson.</u>		25a REC'D BY REGISTRAR <u>1050 York Rd Towson, Md</u>		25b REGISTRAR'S SIGNATURE <u>Wm Cook, Brooks</u>		DATE <u>OCT 10 1967</u>	



1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

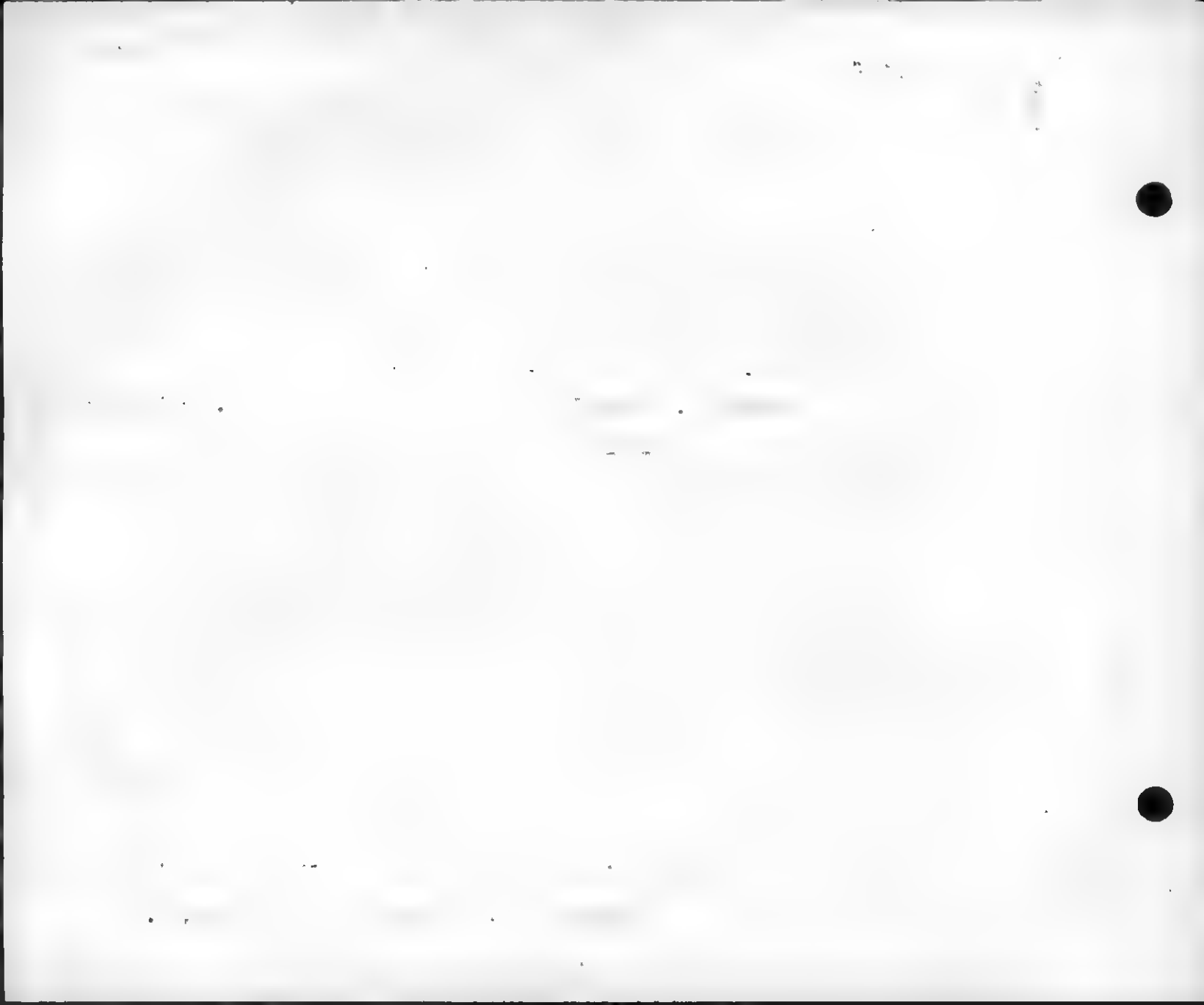
VR A15 (4)
20 M 1/66

13412

CERTIFICATE OF DEATH

13416

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 8417 Pleasant Plains Road	
3 NAME OF DECEASED (Type or print) Alexander First Middle Last CARSWELL, Sr.		4 DATE OF DEATH Month Day Year October 12 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/23 9/29/1900
9 AGE (In years last birthday) 67 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supt. Lever Bros. Oil Refinery.	
10b. KIND OF BUSINESS OR INDUSTRY Scotland		11 BIRTHPLACE (County & State, or foreign country) Scotland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Alexander C. Carswell	
14 MOTHER'S MAIDEN NAME Jessie M. McGilchrist		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 306-10-4372		17 INFORMANT Address Mrs. Margaret Carswell (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/12 , 19 67 , to 10/12 , 19 67 , that (I) (we) last saw the deceased alive on 10/12 , 19 67 , and that death occurred at 6P M, from causes and on the date stated above.			
22a. SIGNATURE Jaime Singzon, M.D.		22b. DATE SIGNED 10-12-67	
22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/16/67.	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR OCT 16 1967	25b. REGISTRAR'S SIGNATURE Charles Young



DATE OCT 25 1967 Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

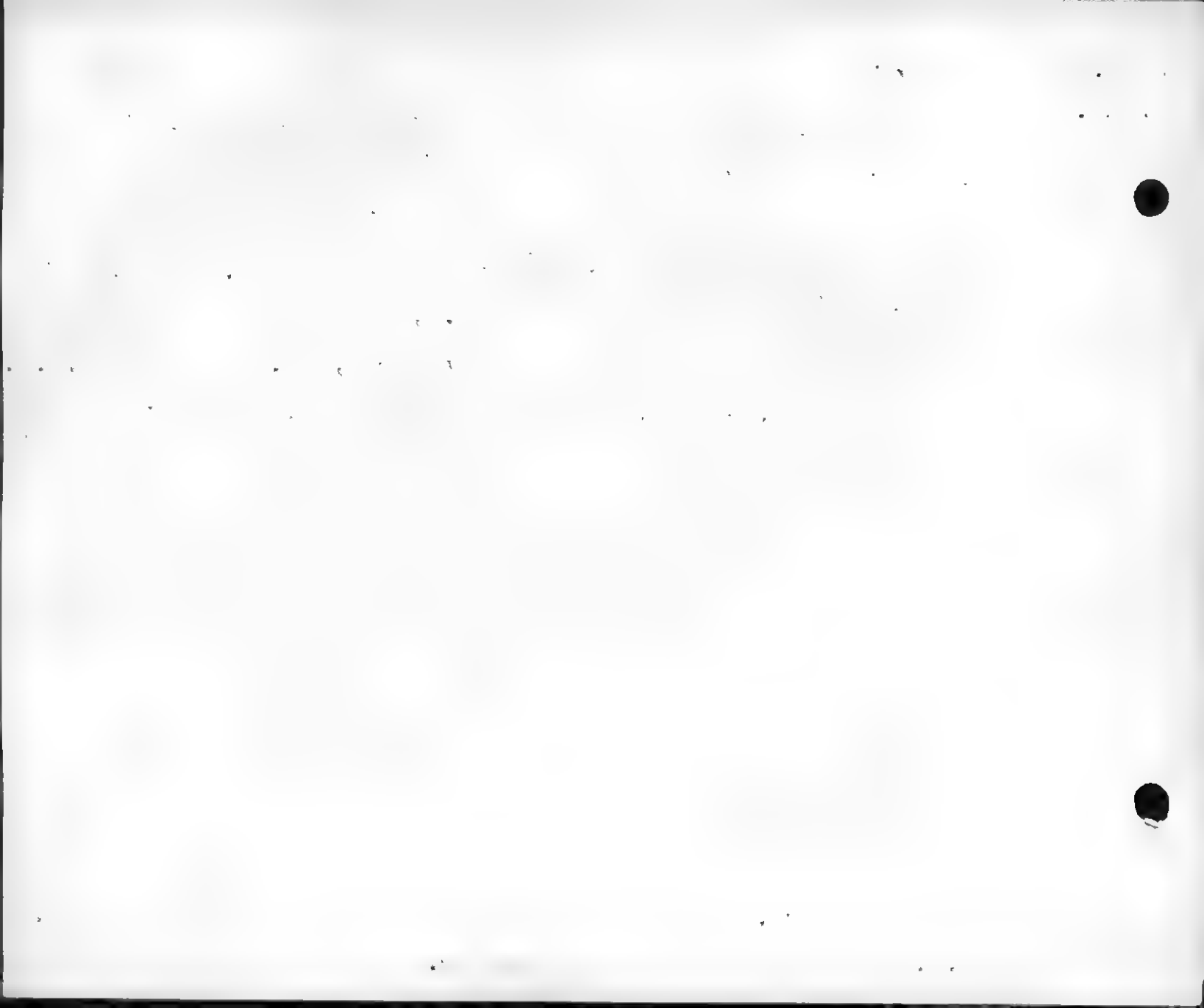
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived - Institution Residence before admission) a. STATE MARYLAND COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Parkville		c. LENGTH OF STAY (In 1b) 1 3/4 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3416 E. Joppa Rd 34		e. STREET ADDRESS 3416 E. Joppa Rd 34	
3 NAME OF DECEASED (Type or print) ALBERTA CHARLOTTE CHASE		4 DATE OF DEATH Month OCT. Day 10 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 8, 1927
9 AGE (in years lost birthday) 40 yrs		10 IF UNDER 1 YEAR Months 40 Days 40 Hours 40 Min 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11 BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARCHIE G. WILKINS		14 MOTHER'S MAIDEN NAME CATHERINE C. CALDWELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 7851	
17 INFORMANT C. RAYMOND McLAUGHLIN		18 ADDRESS 7851 RIVERDALE RD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Gastroenteritis (c) Cirrhosis of liver		INTERVAL BETWEEN ONSET AND DEATH undet undet undet	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOAN C. HYLE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) 7527 Belvid Rd 36	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 13/67	
23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL		23d. LOCATION (City or town) (County) (State) BALTIMORE MD.	
24 FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

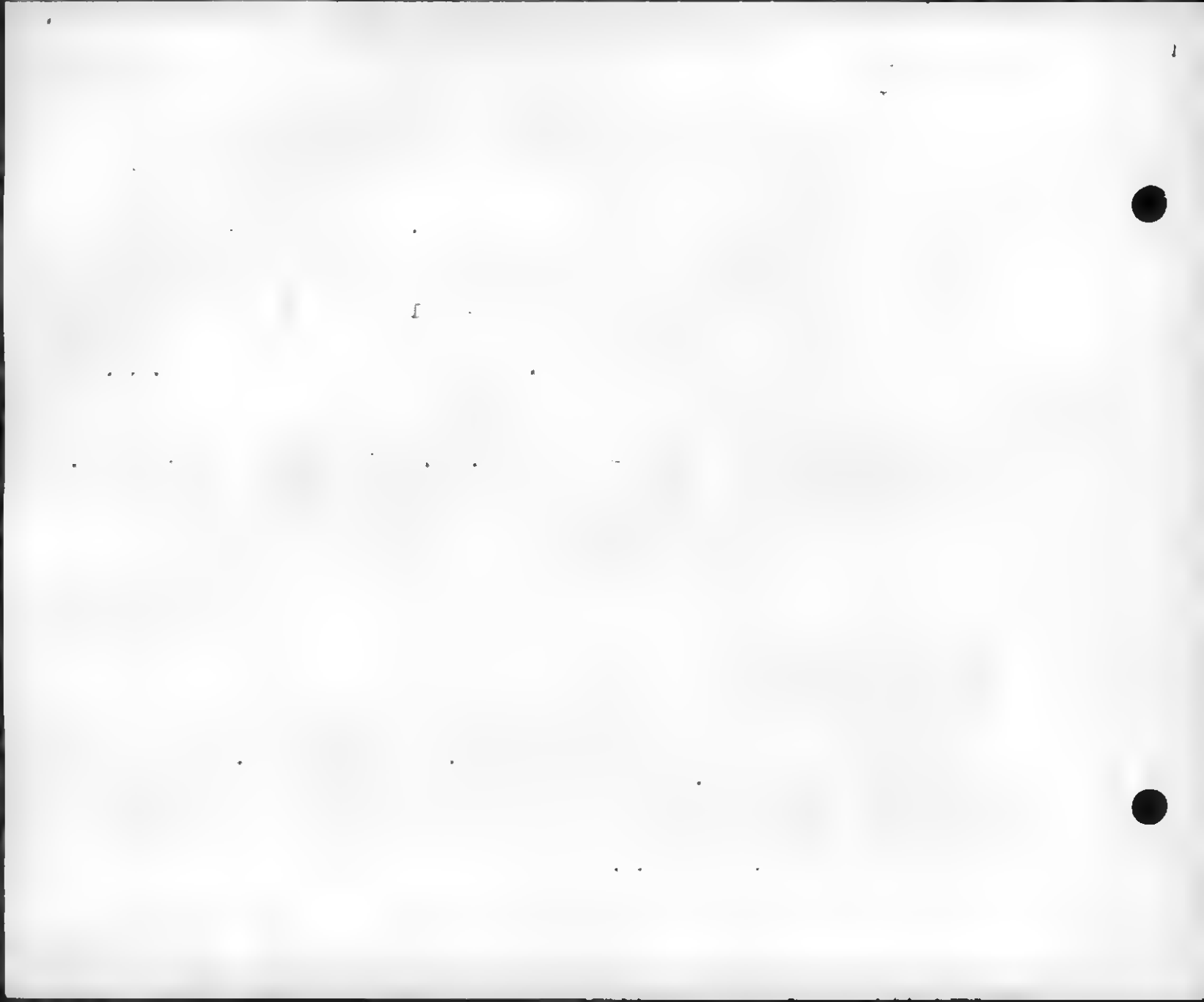
CERTIFICATE OF DEATH

13419

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY in b 44 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 401 E. Townsend Avenue	
3. NAME OF DECEASED (Type or print) First HERBERT Middle CHRISTOPHER Last e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month OCTOBER Day 21 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/91
9. AGE in years (to birthday) 76		10. F UNDER 1 YEAR Months Days 11. F UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Business Bldg.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Christopher		14. MOTHER'S MAIDEN NAME Anna Blaich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-01-95-79	
17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) LYMPHOSARCOMA X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Sept. 7 , 19 67 , to Oct. 21 , 19 67 that (1) (we) last saw the deceased alive on Oct. 21 , 19 67 , and that death occurred at 4:00AM from causes and on the date stated above			
22a. SIGNATURE Elsa M. Goris M.D.		22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) ELSA M. GORIS, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR McCully Funeral Home		25a. REC'D BY REGISTRAR 237 Patapsco Ave Baltimore, Maryland	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13418

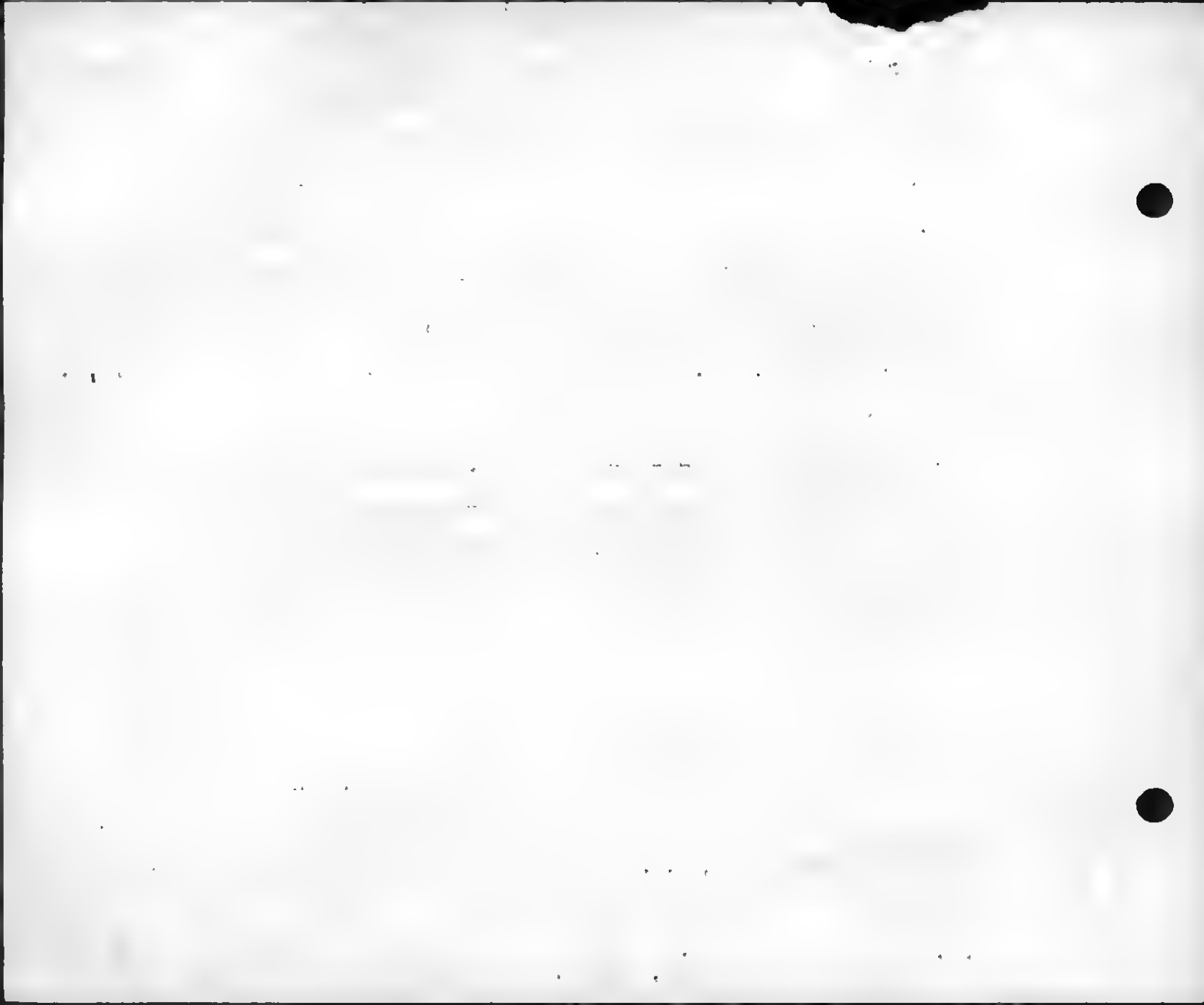
CERTIFICATE OF DEATH

13420

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an: Residence before adm ssion) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #21218	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 627 Parkwyrrth Avenue			e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Frank Henderson CLARK				4. DATE OF DEATH Month Day Year October 10 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1900		9. AGE (n years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-B&O and Dept. of Recreation			10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank H. Clark				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 705-03-1178		17. INFORMANT Mrs. Hildreth E. Clark (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolism & infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b): Intramural thrombosis DUE TO (c): Acute myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 16, 19 67 , to October 10 19 67 that (I) (we) last saw the deceased alive on October 10 19 67 , and that death occurred at 11:20 PM from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED October 11, 1967	
22c. PHYSICIAN'S NAME (Type) Elmo Gayoso, M.D.				22d. ADDRESS 7620 York Road Towson, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/67		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek		23d. LOCATION (City or Town) (County) (State) New Windsor, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.				25a. REC'D BY REGISTRAR OCT 11 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 20 Film DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
394 11-6-67 amalt items #13 14 & 23b Film #G391 11/13/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13421

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY 1		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4			c. LENGTH OF STAY IN 1b Baltimore 21206		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Ina Middle B. Last Clark			4 DATE OF DEATH Month October Day 28 Year 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-11-1877	9 AGE (in years last birthday) 90 yrs	FUNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUA. OCC. PAT. ON (Give kind of work done during most of working life, even if retired) Clark		10b. KIND OF BUSINESS OR INDUSTRY Lehigh Valley Railroad		11 BIRTHPLACE (State or foreign country) New York	
13 FATHER'S NAME Austin C. Mead			14 MOTHER'S MAIDEN NAME Francelia Woodworth		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO 715-16-9498		
17 INFORMANT C. Mrs Ruth Hanson			Address 4611 Ridgeway Road 6		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism DJE TO (b) Fracture of Left Hip DJE TO (c) 48 hrs					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in bedroom at home		
20c. TIME OF INJURY Month, Day, Year 9:20 a.m. Oct. 26 1967			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) (County) (State) Rullerton Balto. Md.		
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell			22. DATE SIGNED 10/28/67		
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.			Address (Street, city, town, or county) Casanova/Cazenovia New York		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-14-1967		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	
24. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 2401 Belair Road		25a. REC'D BY REGISTRAR NOV 1 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

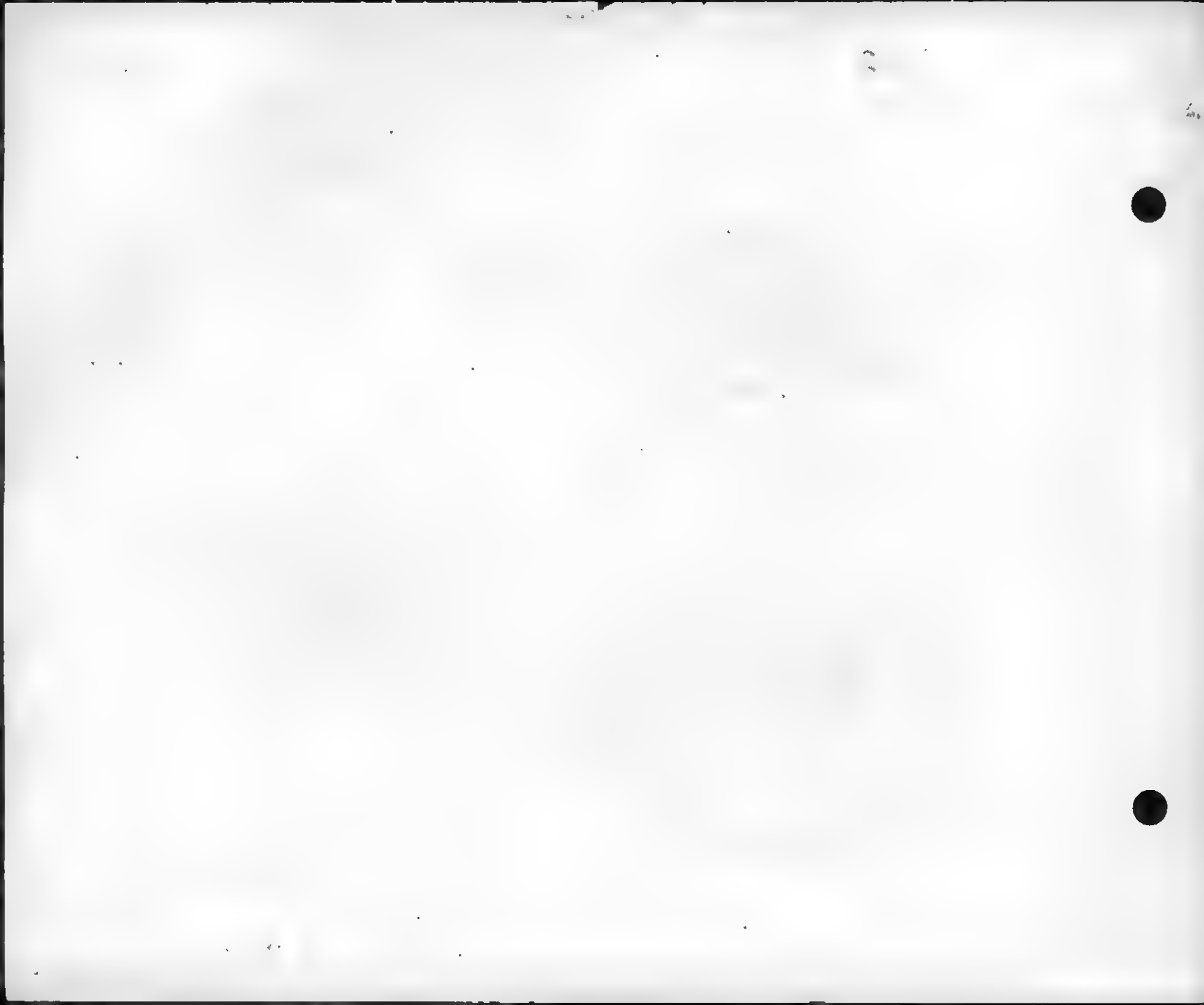
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13418

13422

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 Beaumont Ave.		d. STREET ADDRESS 14 Beaumont Ave	
3 NAME OF DECEASED (Type or print) Joseph A. Codd		4 DATE OF DEATH Month October Day 24 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 1st, 1897
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		9b AGE (In years last birthday) 70	9c IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY State Roads Comm.	11 BIRTHPLACE (County & State, or foreign country) Maryland
13 FATHER'S NAME Patrick J. Codd		14 MOTHER'S MAIDEN NAME Catherine Sinnott	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-05-9587	
17 INFORMANT James Leo Codd		Address 14 Beaumont Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO (b) Atherosclerosis DUE TO (c) Yacer			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Vascular left hemisphere due to Cerebral Thrombosis			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 67 to Oct , 19 67 that (I) (we) last saw the deceased alive on 10/31 19 67 and that death occurred at 3 P M, from causes and on the date stated above			
22a SIGNATURE James J. Nolan		22b DATE SIGNED 10/24/67	
22c PHYSICIAN'S NAME (Type) J J NOLAN		22d ADDRESS Baltimore, Md. 21229	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Oct. 27/67	23c NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	23d LOCATION (City or town) (County) (State) Balto Md
24 FUNERAL DIRECTOR Farley Cavanaugh Funeral Home		25a REC'D BY REGISTRAR DATE OCT 30 1967	25b REGISTRAR'S SIGNATURE John J. Jones



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13413

13423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN TB 30.4		2 USUAL RESIDENCE (Where deceased lived, if inst. in Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
3 NAME OF DECEASED (Type or print) First Milton Middle E. Last Conner		4 DATE OF DEATH Month Oct. Day 7 Year 19 67	
5. SEX M	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Refrigeration	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 213-09-9540	
17. INFORMANT Miss Mary A. Smith		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis DUE TO (c) 2 wks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." "p.m." 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 20 , 1963, to Oct 7 , 1967, that (I) (we) last saw the deceased alive on Oct 7 , 1967, and that death occurred at 2:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post		22d. ADDRESS 6805 York Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/10/1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR OCT 10 1967	
ADDRESS 4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13420

13424

1 PLACE OF DEATH a. COUNTY BALTO MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON		c. LENGTH OF STAY IN 1b 2 Yrs 1 mo 24	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 6737 WILMONT AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOX LEIGH NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First BERTHA Middle M Last CONWAY		4 DATE OF DEATH Month 10 Day 1 Year 1967	
5 SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-1-83
9 AGE (In years lost by day) 84 yrs		10 IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		11b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Liebno		14. MOTHER'S MAIDEN NAME Wilhelmina Kluth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 416-01-7393	
17. INFORMANT Mrs. Gwendolyn R. Pearce		Address 511 Lucia Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Atherosclerosis, generalized. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MARCH 19, 1964 , to SEPT. 30, 1967 , that (I) (we) last saw the deceased alive on SEPT. 30, 1967 , and that death occurred at 4:10 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Gilbert E. Rudman, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22b. DATE SIGNED OCT. 2, 1967
22c. PHYSICIAN'S NAME (Type) GILBERT E. RUDMAN, M.D.		22d. ADDRESS 4701 LIBERTY HTS. AVE.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-3-1967	23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park	23d. LOCATION (City or town) (County) (State) Carroll Co., Md.
24. FUNERAL DIRECTOR G. Howard Strong		ADDRESS 3207 W. North Ave.,	25a. REC'D BY REGISTRAR OCT 3 1967
		25b. REGISTRAR'S SIGNATURE G. Howard Strong	



10 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13421

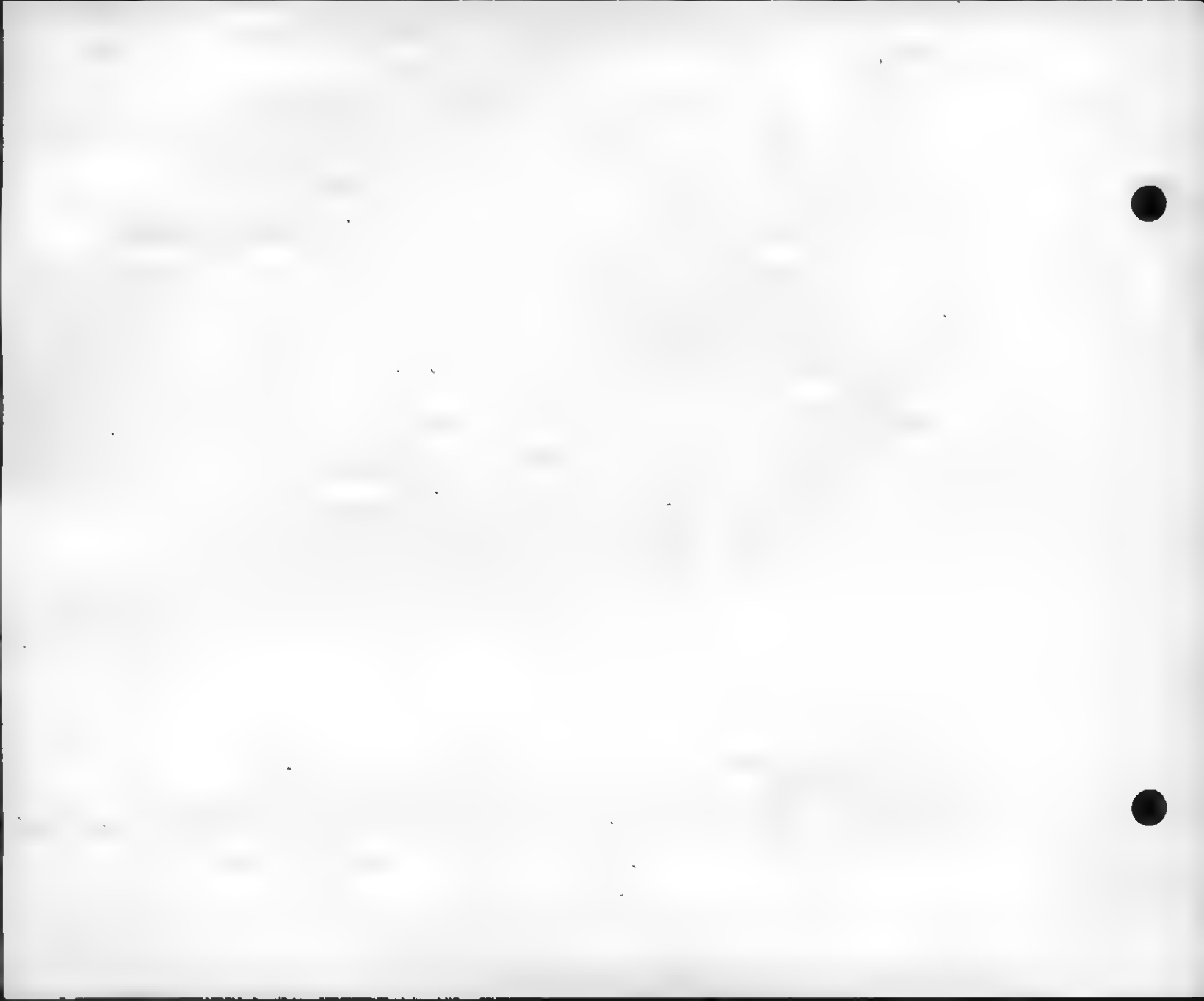
CERTIFICATE OF DEATH

13425

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN <u>ib</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>305 Sacred Heart Lane</u>		d. STREET ADDRESS <u>305 Sacred Heart Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Reynold A. Cover</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>10</u> - Year <u>1967</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>January 8, 1899</u>
9 AGE (In years last birthday) <u>68</u> yrs.		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>East Liberty</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Harry M. Cover</u>		14 MOTHER'S MAIDEN NAME <u>Mary E. Humphreys</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-3265</u>	
17 INFORMANT <u>ROSE A COVER</u>		Address <u>305 Sacred Heart Lane</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>JULY 4, 1966</u> , to <u>OCT. 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT. 6, 1967</u> , and that death occurred at <u>1:59 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard H. Gendason</u>		22b. DATE SIGNED <u>OCT. 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD H. GENDASON MD</u>		22d. ADDRESS <u>REISTERSTOWN, Md. (21136)</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10-13-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Wood Ridge</u>		23d LOCATION (City or Town) (County) (State) <u>Pikesville Balto Md</u>	
24 FUNERAL DIRECTOR <u>Lowry Byers</u>		25a REC'D BY REGISTRAR DATE <u>OCT 13 1967</u>	
25b REGISTRAR'S SIGNATURE <u>J. J. J. J.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13422

Item #8 Film #G39L 1530767 ph

CERTIFICATE OF DEATH

13426

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 7917 East End Drive	
3 NAME OF DECEASED (Type or print) Julian Cox		4 DATE OF DEATH October 24 1967	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 17, 1908
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Alexander Cox		14. MOTHER'S MAIDEN NAME Susan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism, massive, left lung DUE TO (b) 701 A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 701 A		INTERVAL BETWEEN DEATH AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from Nov. 13, 1961 to Oct. 24, 1967 , that the (we) last saw the deceased alive on Oct. 24, 1967 , and that death occurred at 12:20 P. M. from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/67	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem		23d. LOCATION (City or Town) (County) (State) A A Co Md	
24. FUNERAL DIRECTOR McCully		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE OCT 26 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

7 1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13422
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN TB <u>14 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3435 YARDLEY DRIVE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> <u>21222</u> d. STREET ADDRESS <u>3435 YARDLEY DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>CARRIE HERRING CROSWELL</u> First Middle Last 4. DATE OF DEATH <u>10/10/1967</u> 19 Month Day Year 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>FEB. 15, 1890</u> 77 yrs. 9. AGE (In years last birthday) <u>77</u> yrs. If UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD CROSWELL</u> 14. MOTHER'S MAIDEN NAME <u>FLORENCE I. KLAUSMAN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>MRS. HELEN KOPPELMAN</u> Address <u>3456 YORKWAY DUNDALK</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-26-67</u> to <u>10-10-67</u> , that (I) (we) last saw the deceased alive on <u>10-10-67</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel J. Hankin</u> M.D.		22b. DATE SIGNED <u>10-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel J. Hankin, M.D.</u>		22d. ADDRESS <u>3479 Liberty Pkwy. Baltimore, Md. 21222</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>BURIAL</u> <u>10/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK HAWN</u>	
23d. LOCATION (City, town or county) (State) <u>BALTO. Co., MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Haddy, Dundalk, MD</u> ADDRESS	
25a. REC'D BY REGISTRAR <u>10-16-67</u> DATE		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

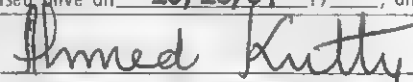



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13424

13424

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b 51 DAYS		d. STREET ADDRESS 7914 33rd Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE L. CUTLER		4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/99
9. AGE (In years) 68 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY ENGINEER	
10b. KIND OF BUSINESS OR INDUSTRY NATL. BISCUIT CO.		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE CUTLER	
14. MOTHER'S MAIDEN NAME TERESA BODECK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO 213 01 45 46		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that this hospital attended the deceased from <u>8/26/67</u>, 19<u>67</u>, to <u>10/18/67</u>, 19<u>67</u>, that (we) last saw the deceased alive on <u>10/18/67</u>, 19<u>67</u>, and that death occurred at <u>2:50AM</u> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 10/18/67	
22c. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D.		22d. ADDRESS VAH PORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/20/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME 2601 E. Madison St. Baltimore, Md.		25a. REC'D BY REGISTRAR OCT 20 1967	
25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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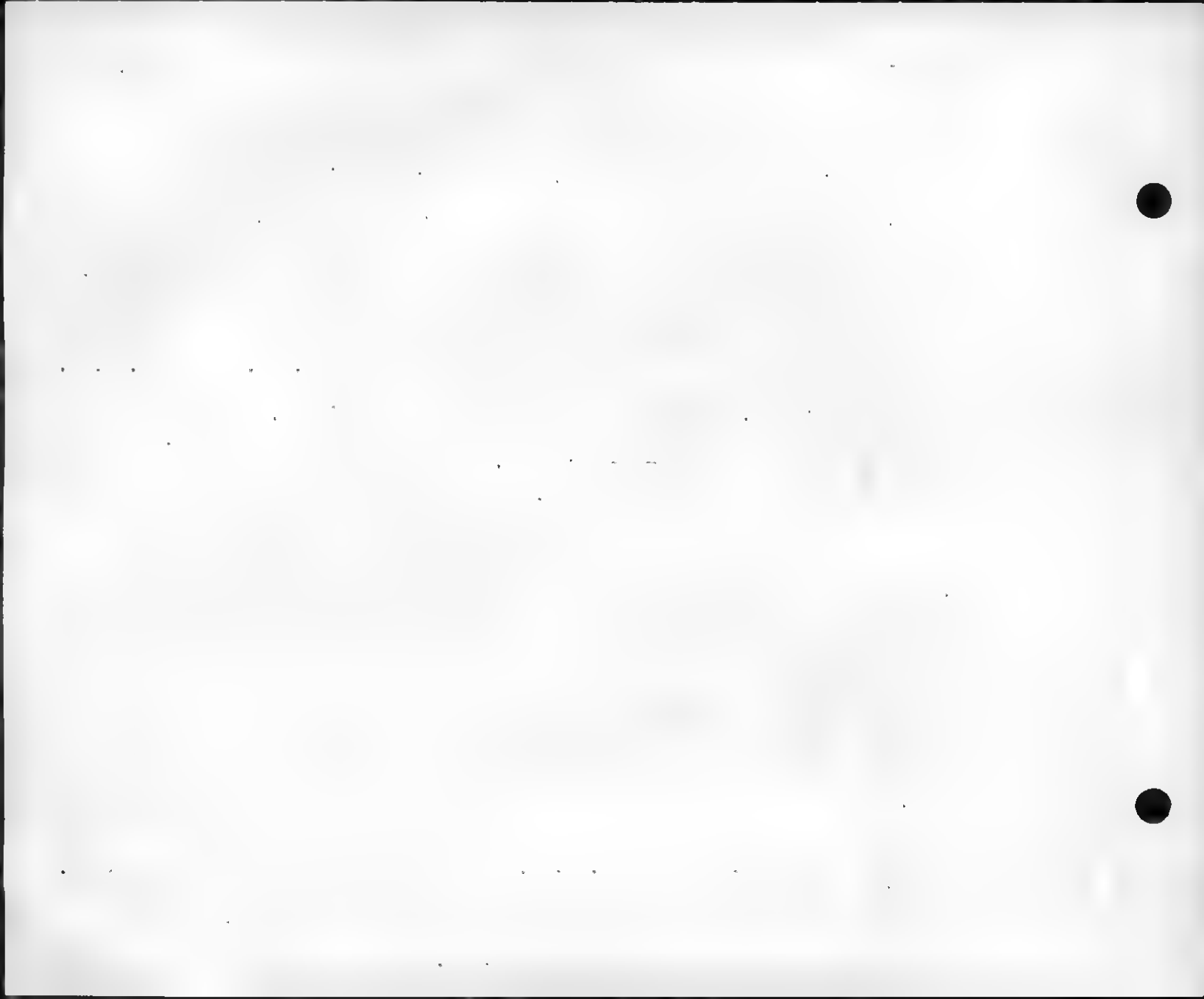
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13429

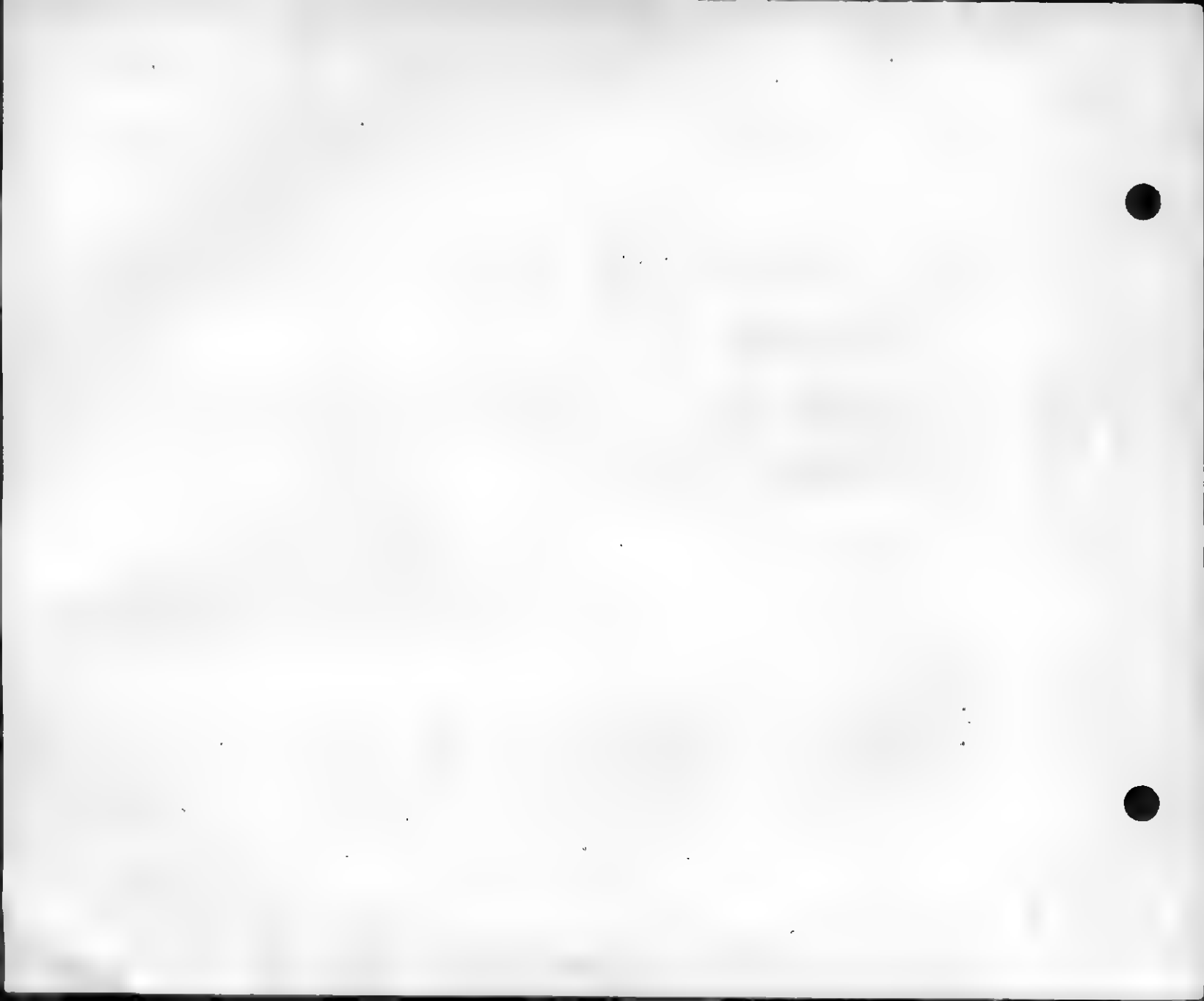
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		e. STREET ADDRESS 403 Hilton Avenue	
3 NAME OF DECEASED (Type or print) Wilhelmina Maria Dalcour		4 DATE OF DEATH Month Oct. Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1902
9. AGE (in years last birthday) 65 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gustave T. Dalcour		14. MOTHER'S MAIDEN NAME Guillermina C. de Bullet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-3131	
17. INFORMANT Catonsville, Md. 21228		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic cerebro-cardiovascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from April 19, 1956 to Oct 21, 1967 , that (I) (we) last saw the deceased alive on Oct 20, 1967 , and that death occurred at 8:34 A.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Nesbitt Jr.		22b. DATE SIGNED 10-23-67	
22c. PHYSICIAN'S NAME (Type) John A. Nesbitt Jr. M. D.		22d. ADDRESS 1009 Frederick Rd. Catonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Easton Funeral Home		25a. REC'D BY REGISTRAR OCT 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

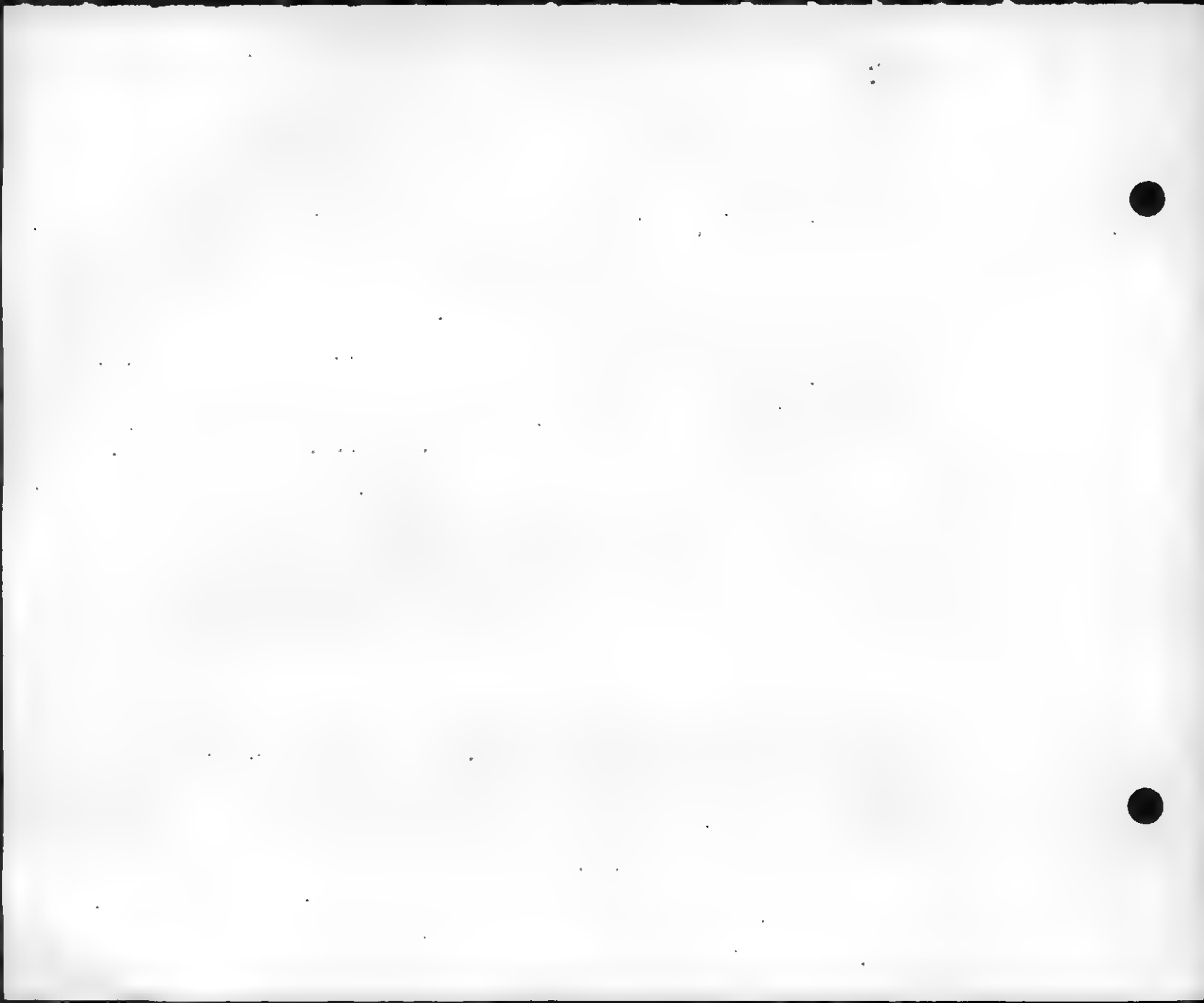
<div> <div>1</div> <div> <div>Item #2, 8, 9, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100</div> <div> <div>13425</div> <div>Item #5, 6, 8, 9 & 12</div> </div> </div> <div> <div>13430</div> <div>13430</div> </div> </div>															
<div>1. PLACE OF DEATH</div> <div>a. COUNTY <u>Baltimore County</u> MARYLAND</div>						<div>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</div> <div>a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u></div>									
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div><u>Catonsville</u></div>						<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div><u>Millersville</u></div>									
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div><u>Caton Ridge Nursing Home</u></div>						<div>d. STREET ADDRESS</div> <div><u>Box 439-A, Route 1</u></div>									
<div>3. NAME OF DECEASED (Type or print)</div> <div>First <u>MARY</u> Middle <u>DAUGHTERTY</u> Last <u></u></div>						<div>4. DATE OF DEATH</div> <div>Month <u>10</u> - Day <u>3</u> - Year <u>1967</u></div>									
<div>5. SEX</div> <div><u>Female</u></div>		<div>6. COLOR OR RACE</div> <div><u>W</u></div>		<div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div><u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div><u>Aug. 1, 1898</u></div>		<div>9. AGE (in years last birthday)</div> <div><u>69</u> yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months <u></u> Days <u></u></div>		<div>IF UNDER 24 HRS.</div> <div>Hours <u></u> Min. <u></u></div>			
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div>				<div>10b. KING OF BUSINESS OR INDUSTRY</div>				<div>11. BIRTHPLACE (County & State, or foreign country)</div>				<div>12. CITIZEN OF WHAT COUNTRY?</div> <div><u>U.S.A.</u></div>			
<div>13. FATHER'S NAME</div> <div><u>Clarence Albert Harrison</u></div>						<div>14. MOTHER'S MAIEN NAME</div> <div><u>Poxie Adali Mathaney</u></div>									
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div>				<div>16. SOCIAL SECURITY NO.</div>				<div>17. INFORMANT</div> <div>Address <u></u></div>							
<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u></div> <div>4201 DUE TO</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u></div> <div>DUE TO</div> <div>(c) <u></u></div>												<div>INTERVAL BETWEEN ONSET AND DEATH</div>			
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div><u>General Paresis - CNS Ines (Latent)</u></div>												<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>			
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</div>											
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. <u>19</u> p.m. <u></u></div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>				<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>				<div>20f. (City or town) (County) (State)</div>			
<div>21. I certify that (I) (this hospital) attended the deceased from <u>July, 1959</u> to <u>10-3-1967</u>, that (I) (we) last saw the deceased alive on <u>10-3-1967</u>, and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.</div>															
<div>22a. SIGNATURE</div> <div><u>Cesar Valle Cauero</u></div>												<div>22b. DATE SIGNED</div> <div><u>10-3-67</u></div>			
<div>22c. PHYSICIAN'S NAME (Type)</div> <div><u>CESAR VALLE CAUERO</u></div>												<div>22d. ADDRESS</div> <div><u>2624 Liberty Rd</u></div>			
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div><u>Removal</u></div>				<div>23b. DATE THEREOF</div> <div><u>10-3-67</u></div>				<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div><u>St. Anselm's Cemetery</u></div>				<div>23d. LOCATION (City, town or county) (State)</div> <div><u>Baltimore, Md.</u></div>			
<div>24. FUNERAL DIRECTOR</div> <div><u>Frank A. Newell</u></div>												<div>25a. REC'D BY REGISTRAR</div> <div><u>10-3-67</u></div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div><u>Charles Judge</u></div>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH										13431	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY _____					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Nursing Home</u>						d. STREET ADDRESS <u>417 Athol Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Beatrice</u> Last <u>Davis</u>						4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12 1832</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>F. Charles Eckenrode</u>						14. MOTHER'S MAIDEN NAME <u>Mary Ellen Lorus</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216 54 6339J1</u>		17. INFORMANT <u>Mrs. M. J. C. Smith</u> Address <u>103 C Rolling Bend Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>atherosclerotic cerebro-cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 3</u> , 19 <u>67</u> , to <u>Oct 12</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-6-67</u> 19 <u>67</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John A. Nesbitt, Jr.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John A. Nesbitt, Jr., M.D.</u>						22d. ADDRESS <u>1009 Frederick Road, Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 14 - 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>				23d. LOCATION (City, town or county) _____ (State) <u>Md.</u>			
24. FUNERAL DIRECTOR <u>Farley Cavanaugh Funeral Home</u>						25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



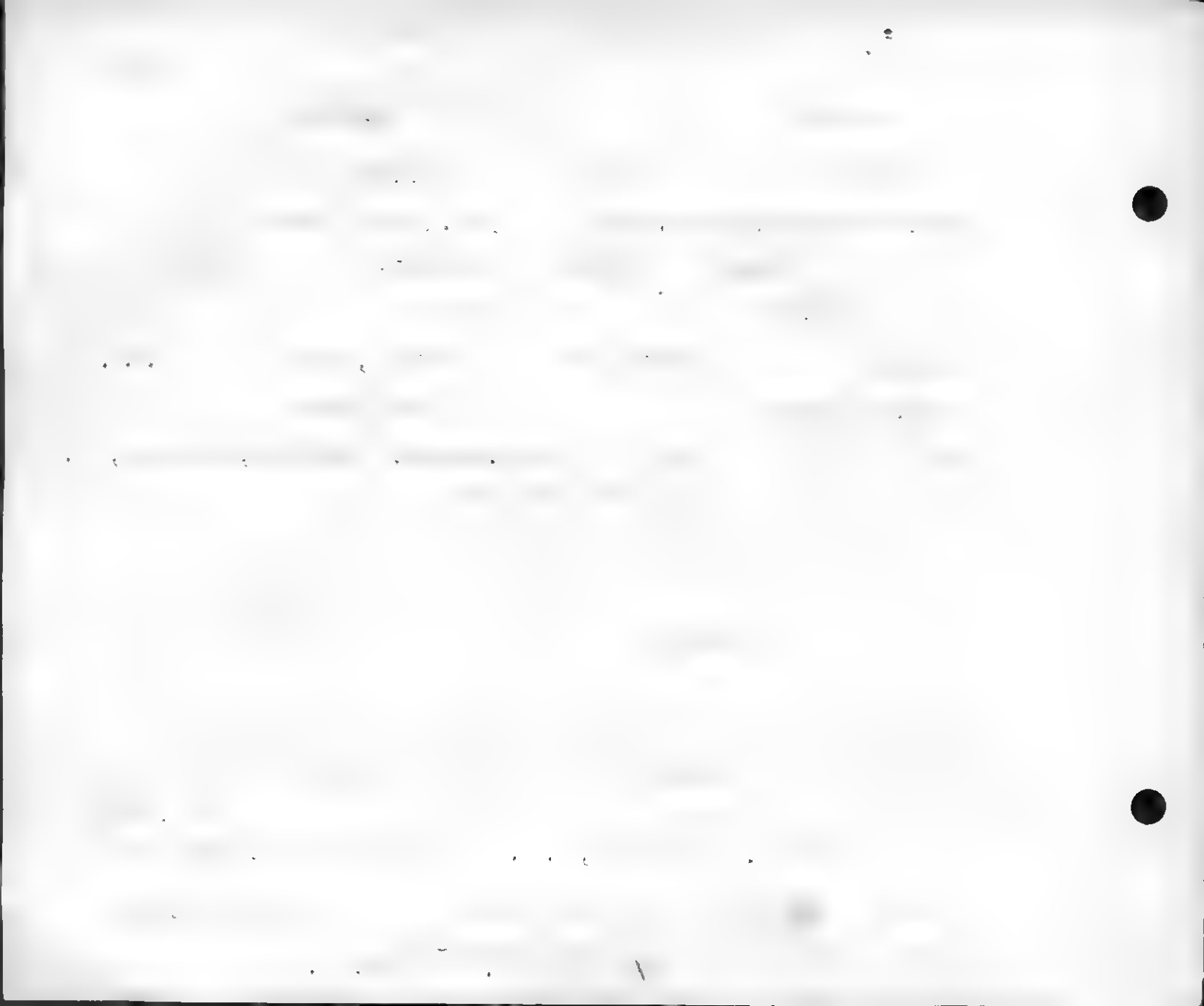
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13432

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 37 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 50 S. MORLEY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle WARNER Last DE SHIELDS				4. DATE OF DEATH Month OCTOBER Day 4 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/16		9. AGE (In years last birthday) 51 yrs	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT			10b. KIND OF BUSINESS OR INDUSTRY PARKING LOT		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. COUNTRY OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES DeSHIELDS				14. MOTHER'S MAIDEN NAME MABEL CAMPER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 212 07 05 97		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) GLIOBLASTOMA GRADE IV DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)
21. I certify that (*) (this hospital) attended the deceased from 8/28/67 , 19____, to 10/4/67 , 19____, that (*) (we) last saw the deceased alive on 10/4/67 , 19____, and that death occurred at 2:10PM from causes and on the date stated above							
22a. SIGNATURE <i>George C. McElpatrick</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/4/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MCELPATRICK, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/19/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Charles H. Powell</i> WILLIAMS FUNERAL HOME				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	
24. ADDRESS 349 SHERODER ST. BALTIMORE, MD.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



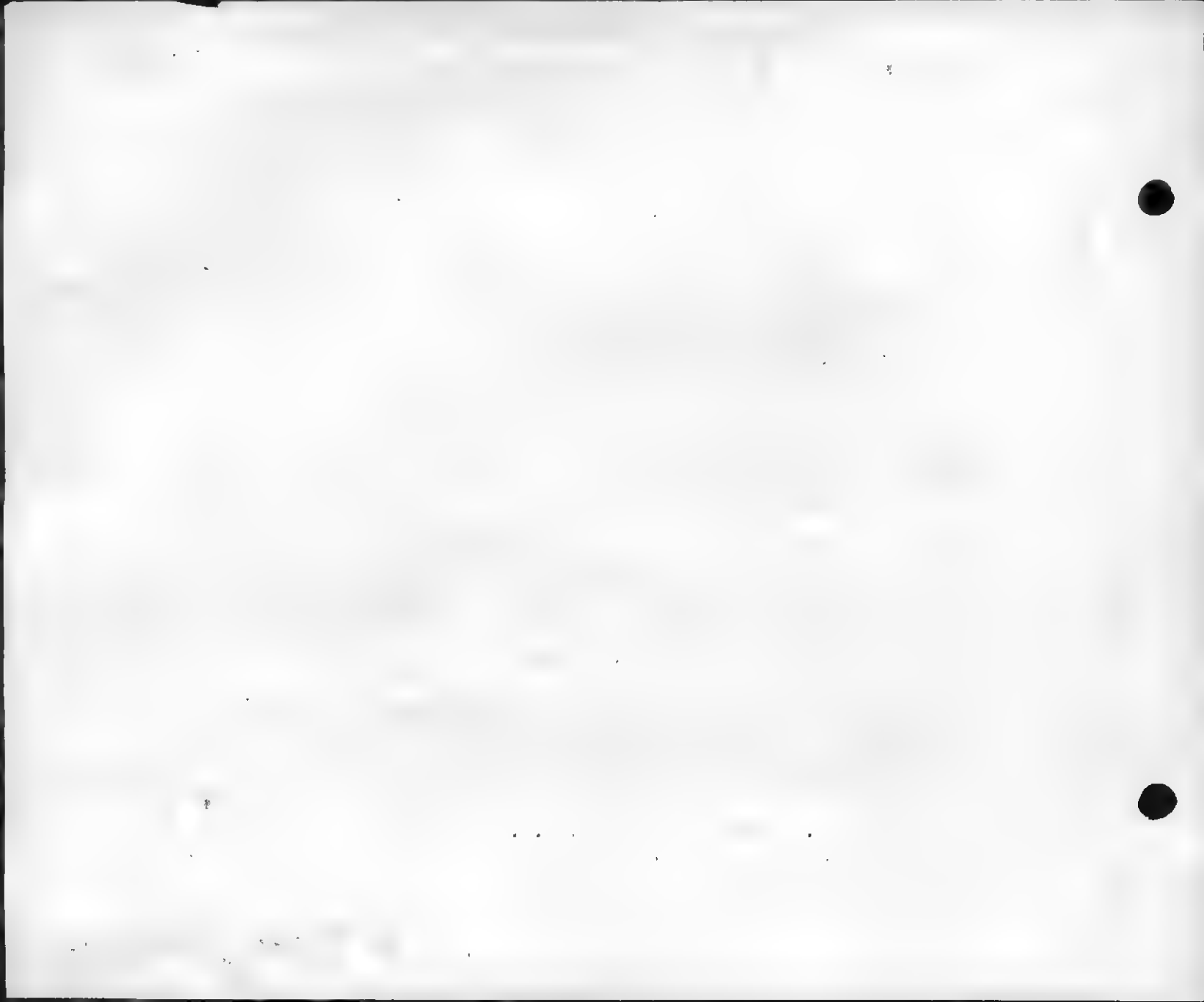
13429

CERTIFICATE OF DEATH

13433

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe, Maryland</u>	
f. STREET ADDRESS <u>4627 Magnolia Ave.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Inez</u> First <u>M.</u> Middle <u>DeVill</u> Last		4. DATE OF DEATH <u>Oct 18</u> Month <u>19</u> Day <u>67</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Editor Ret.</u>		12. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Oregon</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Eugene Davis</u>		16. MOTHER'S MAIDEN NAME <u>Rene ?</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO <u>A 811 4 32</u>	
19. INFORMANT <u>Mr. Edward DeVille- Sparks, Maryland</u>		Address <u>Yeoho Rd.</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>arteriosclerosis generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Diabetes mellitus</u> DUE TO (c) <u>9 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension Cardiovascular Disease. Stroke 1960</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>60</u> , to <u>Oct 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 20</u> , 19 <u>67</u> , and that death occurred at <u>4:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A. Bradley Daugharthy, M.D.</u>		22b. DATE SIGNED <u>10-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thompson Daugharthy</u>		22d. ADDRESS <u>1204 St. Francis Ave., Halethorpe</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

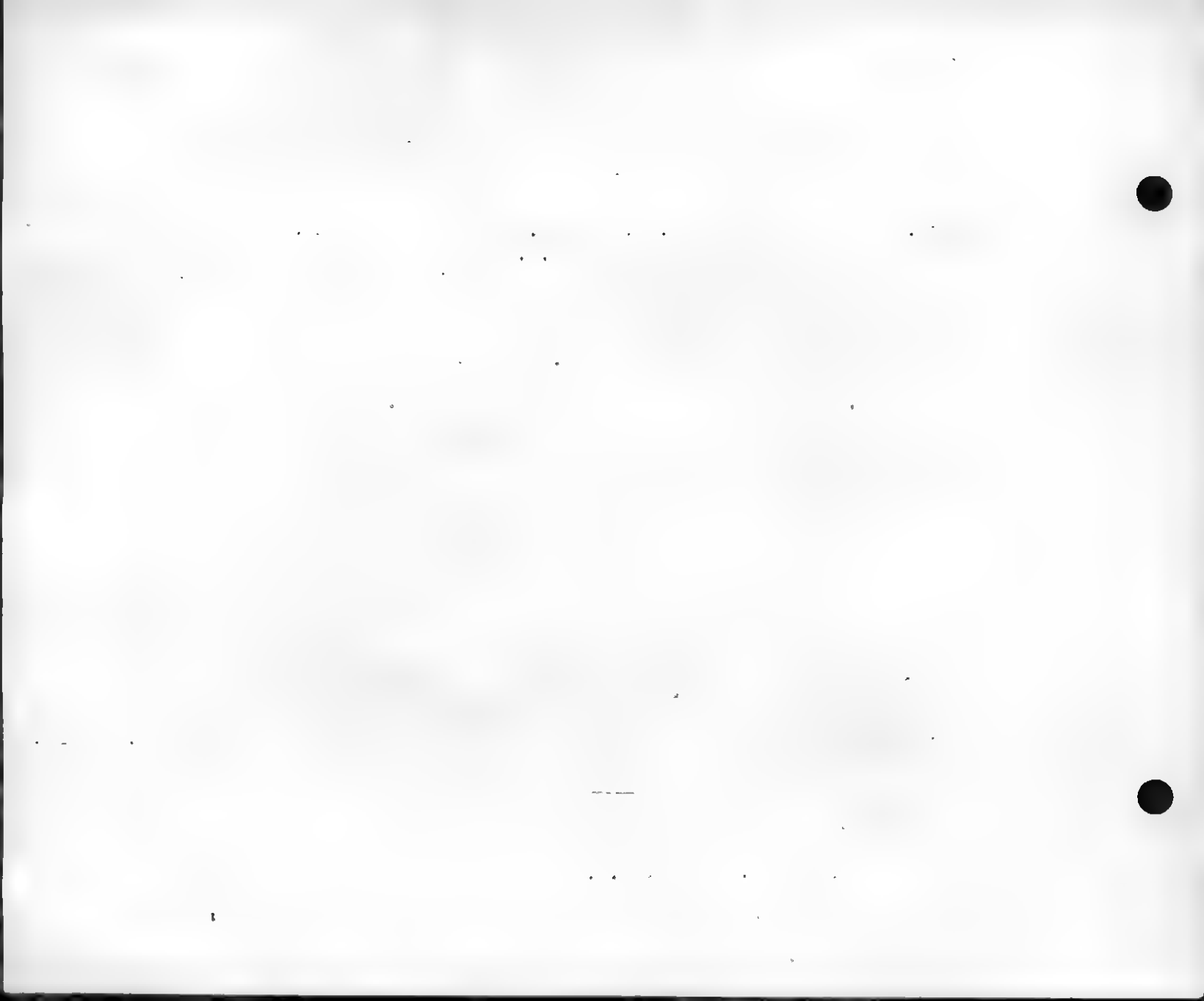
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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13434

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b U	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Beltway 1695 1/4 ml. N. of Alto		d. STREET ADDRESS 646 Plymouth Rd.	
3. NAME OF DECEASED (Type or print) WILLIAM FRANCIS DIEM		4. DATE OF DEATH Month October Day 6 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp.	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Albert M. Diem		14. MOTHER'S MAIDEN NAME Ruth E. Stark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 265-62-2000	17. INFORMANT Robert A. Diem Address 1006 Cedarcroft Rd 21222
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject into auto into tractor trailer	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:20 xxx 10 6 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street	20f. (City or town) Balto. (County) Md. (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson M.D.		22. DATE SIGNED October 6, 1967	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		23a. REC'D BY REGISTRAR OCT 10 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or town) Baltimore, Maryland (County) (State)
24. FUNERAL DIRECTOR Dippel Bro's Inc. 7110 Belair Rd. 21206		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

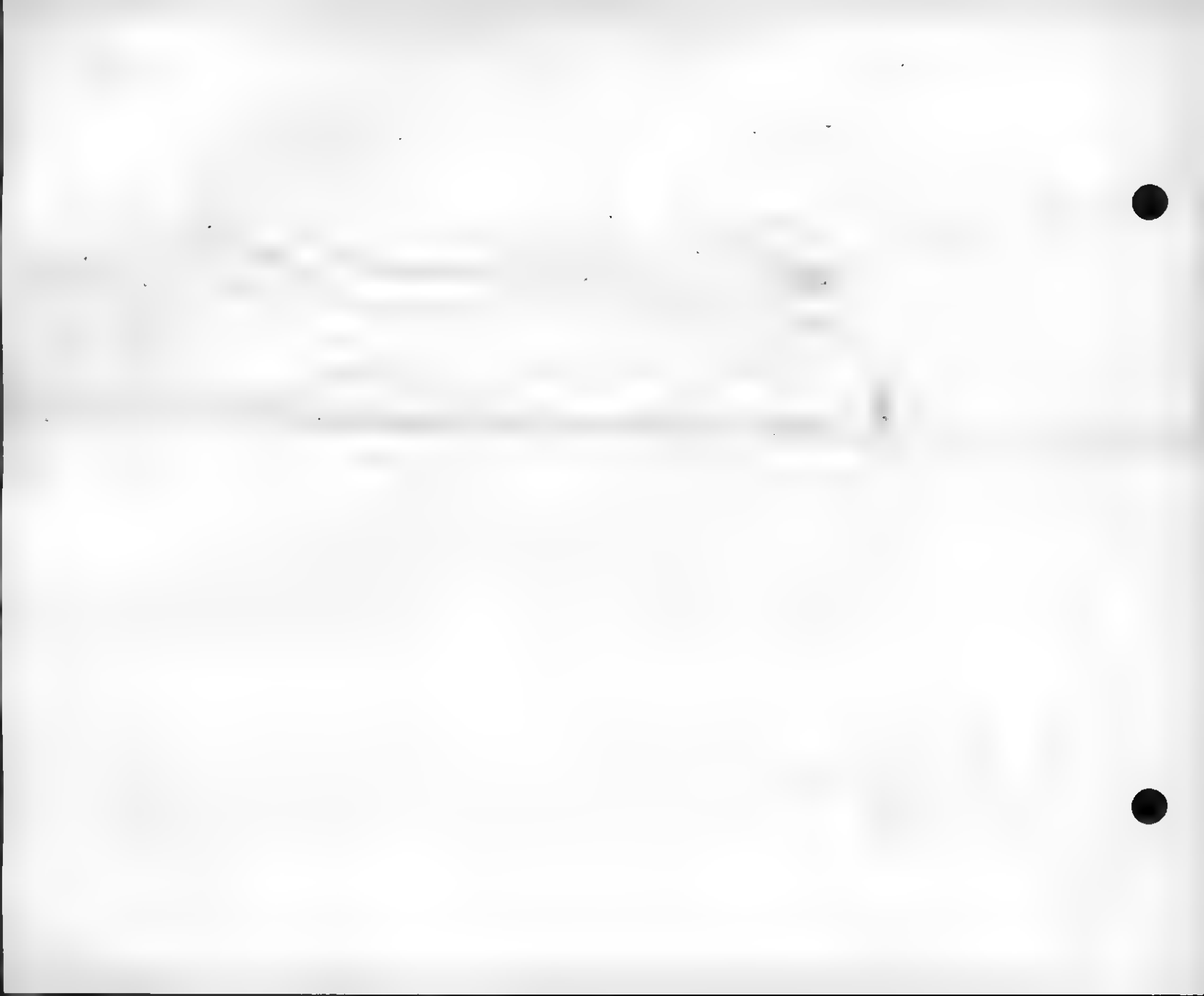
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13431

CERTIFICATE OF DEATH

13435

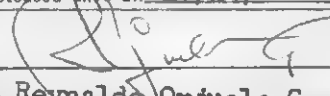
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>		c. LENGTH OF STAY IN TB <u>70 YRS.</u>	c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4321 KENWOOD AVE</u>			d. STREET ADDRESS <u>4321 KENWOOD AVE</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>THOMAS</u> Last <u>DIETEL</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>5</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1883</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months Days Hours Mins
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>PRODUCE SALESMAN MARKET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARKET</u>		11. BIRTHPLACE (County & State or foreign country) <u>GERMANY</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>KUNIGUNDA GEBHARDT</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-270</u>		17. INFORMANT <u>MRS ELIZABETH LENSCH 4321 KENWOOD AVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> 4221 DUE TO (b) <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1946</u> , to <u>OCT 5, 1967</u> that (I) (we) last saw the deceased alive on <u>9-21 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Max R. English MD</u>		22b. DATE SIGNED <u>10-6-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Max R. English MD</u>	
22d. ADDRESS <u>5712 Belair Rd Baltimore Md 21206</u>		22e. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>OCT 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR <u>Lessah Funeral Home 7401 Belair Rd</u>					



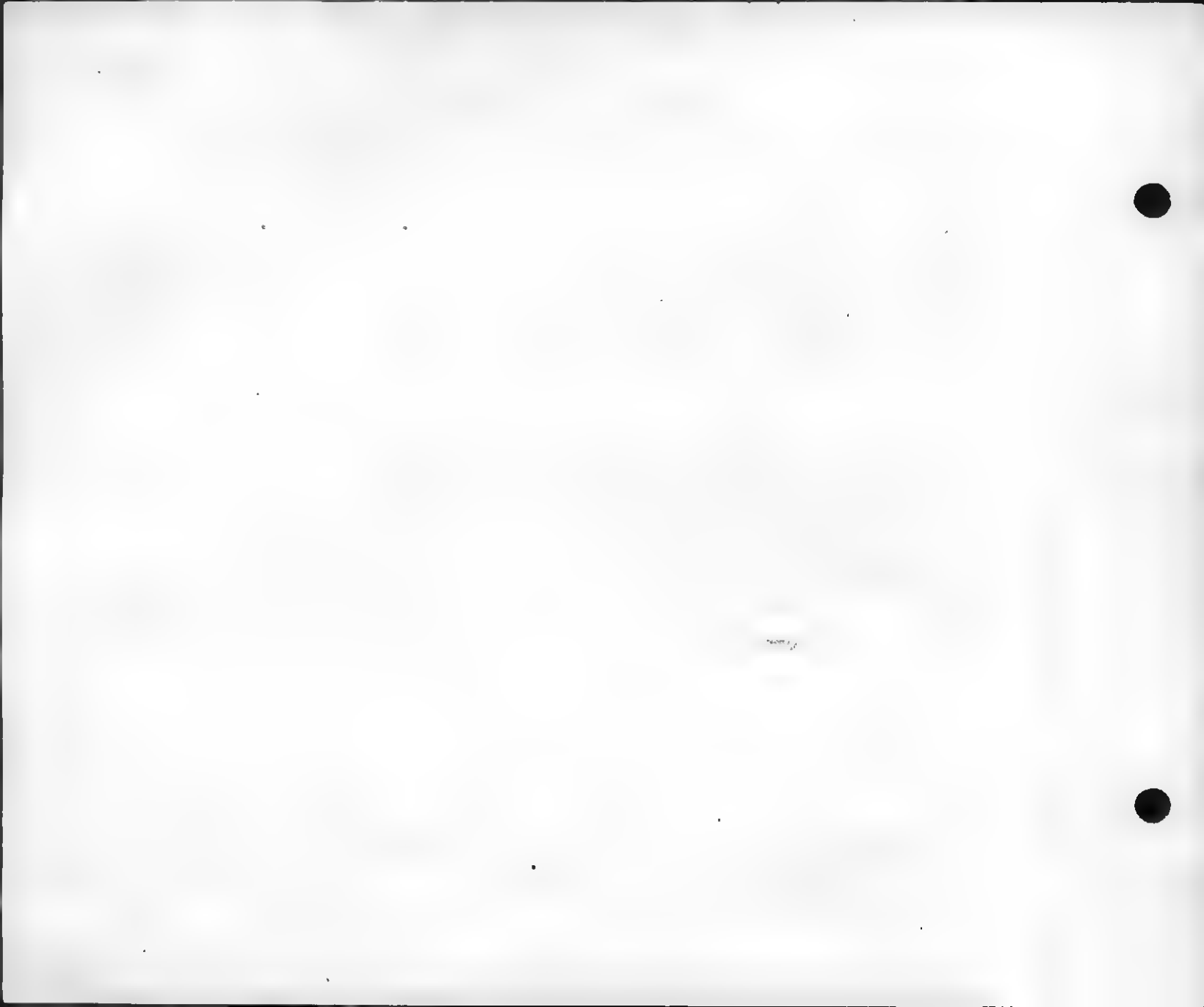
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13436

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21213	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 2006 E. Preston St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaiah Middle Last DIGGS				4. DATE OF DEATH Month October Day 24 Year 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1899		9. AGE (in years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Spencer Point		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Diggs				14. MOTHER'S MAIDEN NAME Mary Glaston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 223-16-9338		17. INFORMANT Address Weather Diggs - Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary thrombo embolism						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. (this hospital) attended the deceased from 9/22/ , 19 67 , to 10/24/ , 19 67 that 4 (we) last saw the deceased alive on 10/24/ , 19 67 , and that death occurred at 2:20PM , from causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED October 24, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Northview Court		23d. LOCATION (City or Town) (County) (State) Balto Md	
24. FUNERAL DIRECTOR Charles Wilson 10000 Crescent Line				25a. REC'D BY REGISTRAR DATE OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



13437

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

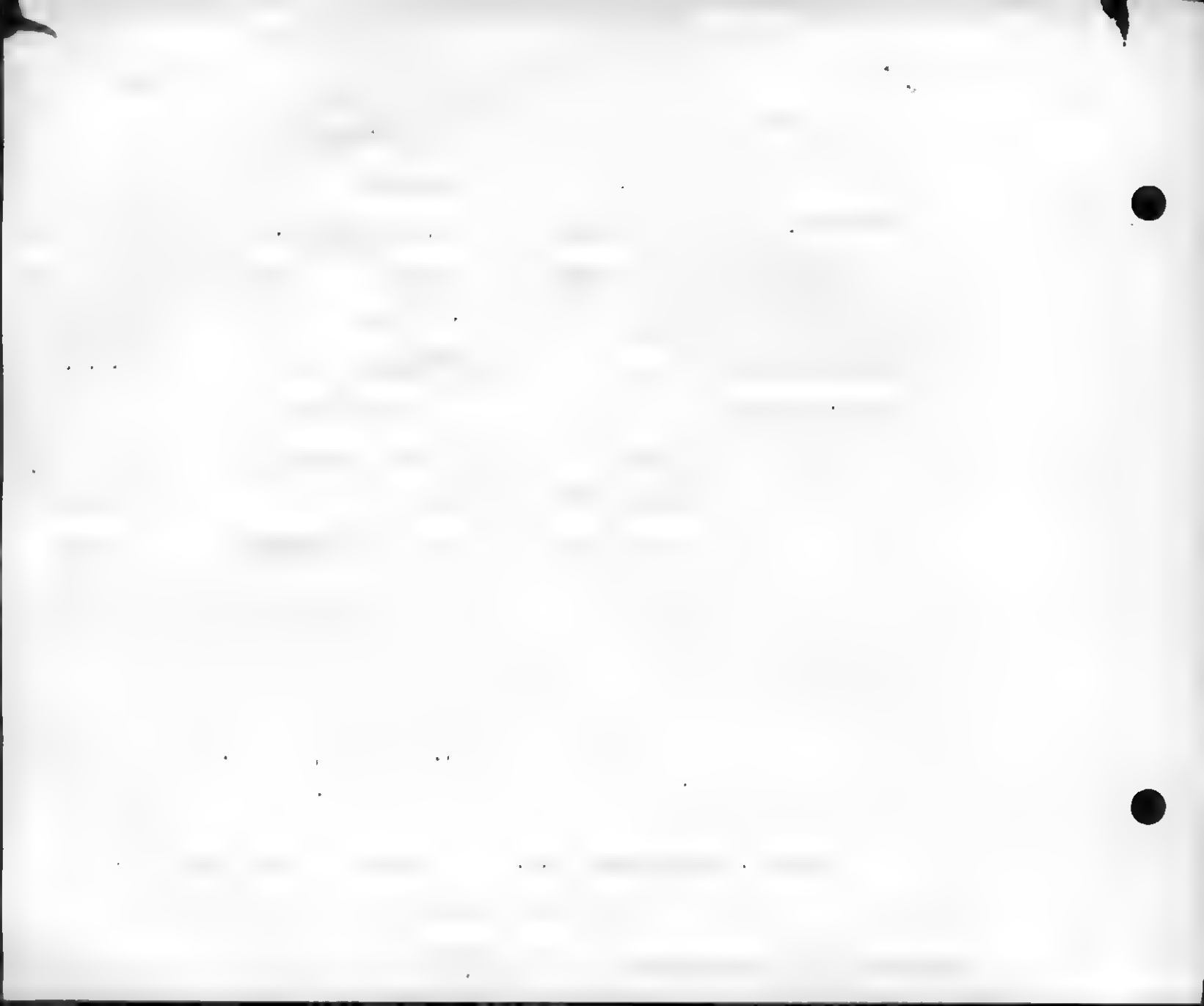
CERTIFICATE OF DEATH

13434

13438

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 37 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 117 S Monroe St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CLIFTON Middle CLYDE Last DORSEY				4 DATE OF DEATH Month October Day 13 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1905		9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR: Months 62 Days 13 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body and Fender work			10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (County & State, or foreign country) Woodbine, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Arthur C. Dorsey				14. MOTHER'S MAIDEN NAME Minnie Shipley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-11			16. SOCIAL SECURITY NO. 214 01 95 30		17. INFORMANT Clinical Recs VA Hospital, Fort Howard Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA METASTATIC RIGHT FEMUR DUE TO (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)		
21. I certify that 10 (this hospital) attended the deceased from Sept. 6 19 67 to Oct. 13, 1967 , that (if we) last saw the deceased alive on Oct. 13, 1967 , and that death occurred at 10:40 from causes and on the date stated above.							
22a. SIGNATURE <i>Madhav D. Barhanpurkar</i>				22b. DATE SIGNED 10/13/67		22c. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.	
22d. ADDRESS VA Hospital, Fort Howard, Md.				22e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-16-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR <i>John R. Slack</i>				25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. FUNERAL HOME ELGINBOTHAM-SLACK FUNERAL HOME							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

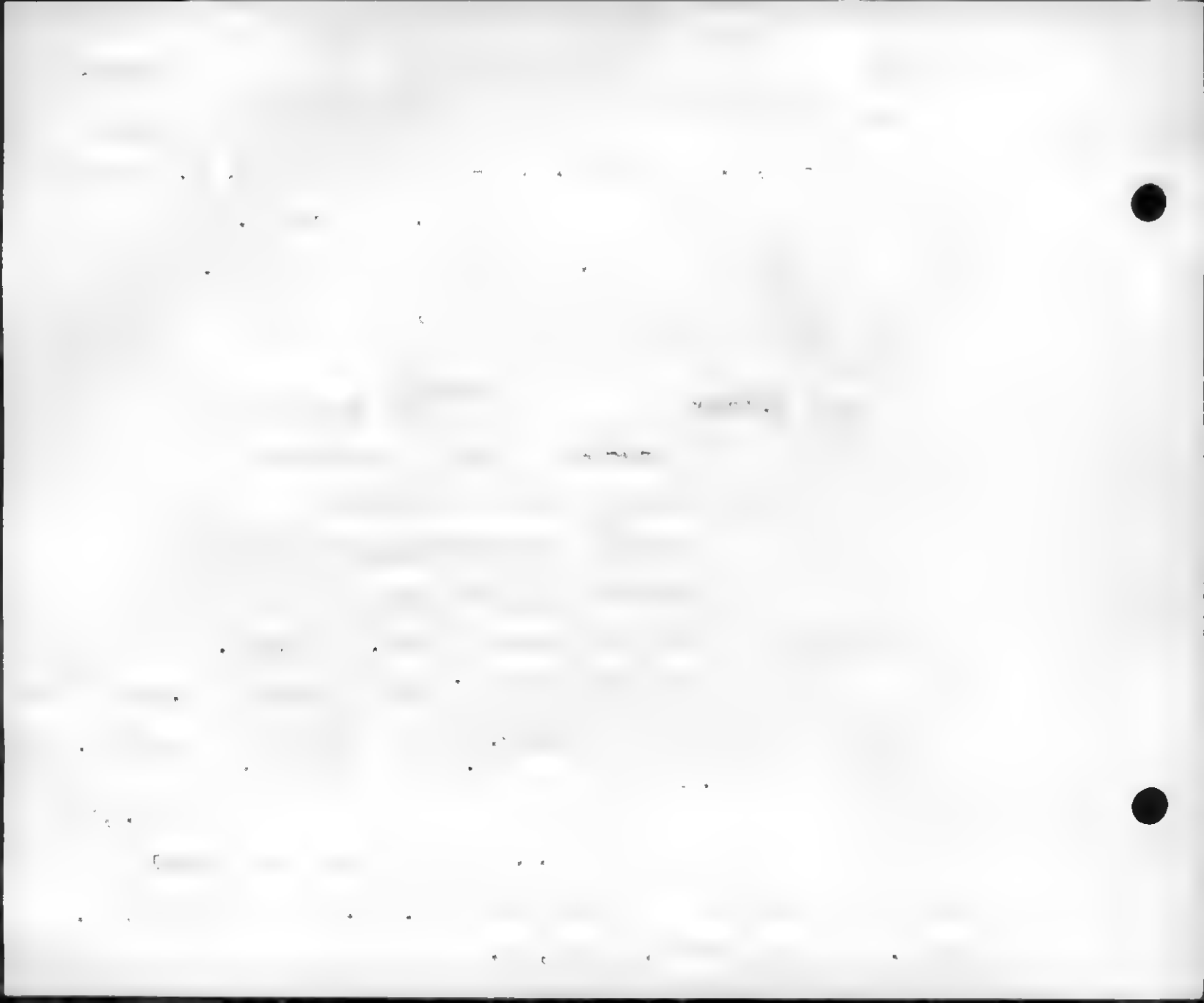
13435

13439

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write nearest town) Catonsville - 28, Md.		c. LENGTH OF STAY In 1b since Nov. 23, 55	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 46 S. Dundalk Avenue	
3 NAME OF DECEASED (Type or print) First Mary Middle G. Last Duffin		4 DATE OF DEATH Month Oct. Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1897
9. AGE (In years last birthday) 70 yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of workable years - if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel O. Caulk		14. MOTHER'S MAIDEN NAME Gertrude Flint Mathaney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-12-1926-22	
17. INFORMANT Spring Grove Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Heart Failure (immediate) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (abnormal EKG) DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recovering from Right Lobar pneumonia (Sept. 14 - 26, 1967)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Operated on Sep. 5, 1967 Comminuted Intertrochanteric Fracture of Rt. Femur (July 29)	
20c. TIME OF INJURY Month, Day, Year July 29, 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dr. J. Frederick, coroner released the body	
21. I certify that (I) (this hospital) attended the deceased from Nov. 23, 19 55 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on Oct. 8, 19 67 , and that death occurred at 1 P. M. from causes and on the date stated above.			
22a. SIGNATURE James Kopits		22b. DATE SIGNED Oct. 8, 1967	
22c. PHYSICIAN'S NAME (Type) James Kopits, M.D.		22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR OCT 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. G.ve Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1-43. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health in its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

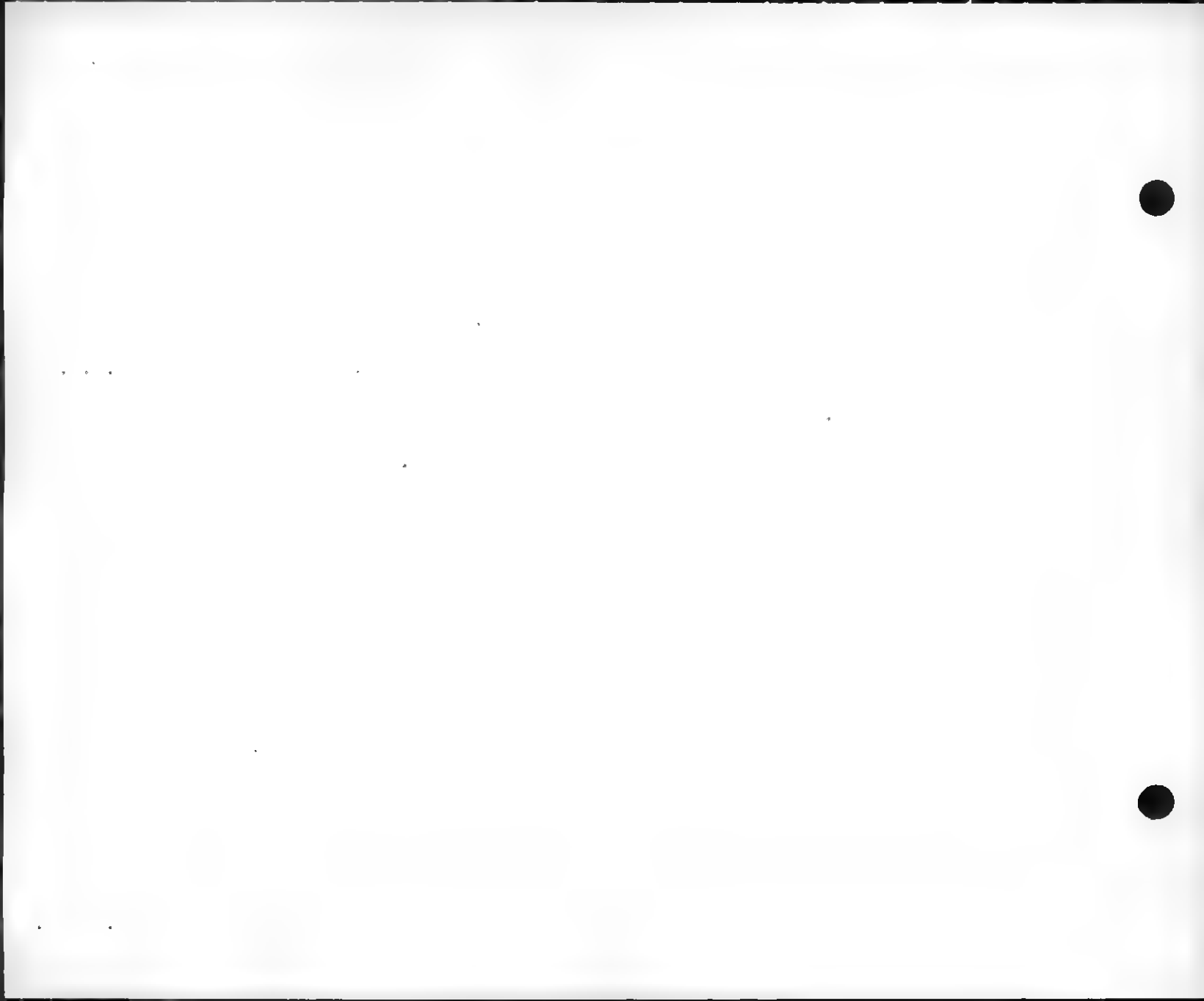
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13436

13440

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MD. b COUNTY BALTO.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b ESSEX 21221 63	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. BELTWAY		e STREET ADDRESS 313 LORRAINE AVE	
3 NAME OF DECEASED (Type or print) First WALLIS Middle WOODROW Last DUNHAM		4 DATE OF DEATH Month OCT. Day 25 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-26-1916
9 AGE (In years, month, day) 50 yrs		10 UNDER 1 YEAR Months 5 Days 10 Hours 10 Min 00	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b KIND OF BUSINESS OR INDUSTRY Sinia Hospital	
11 BIRTHPLACE (State or foreign country) Leon Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME A L.C. Dunham		14 MOTHER'S MAIDEN NAME Lucy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 232-28-7280	
17 INFORMANT Mrs Emma V. Dunham		Address 313 Lorraine Avenue Essex 21221	
18. CAUSE OF DEATH (Enter only one cause per PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Due to (c) Due to		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury MD		22. DATE SIGNED 10/27/67	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, State, Zip) 1000 E. Baltimore Ave. Baltimore, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-30-1967	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.
24. FUNERAL DIRECTOR John A. Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

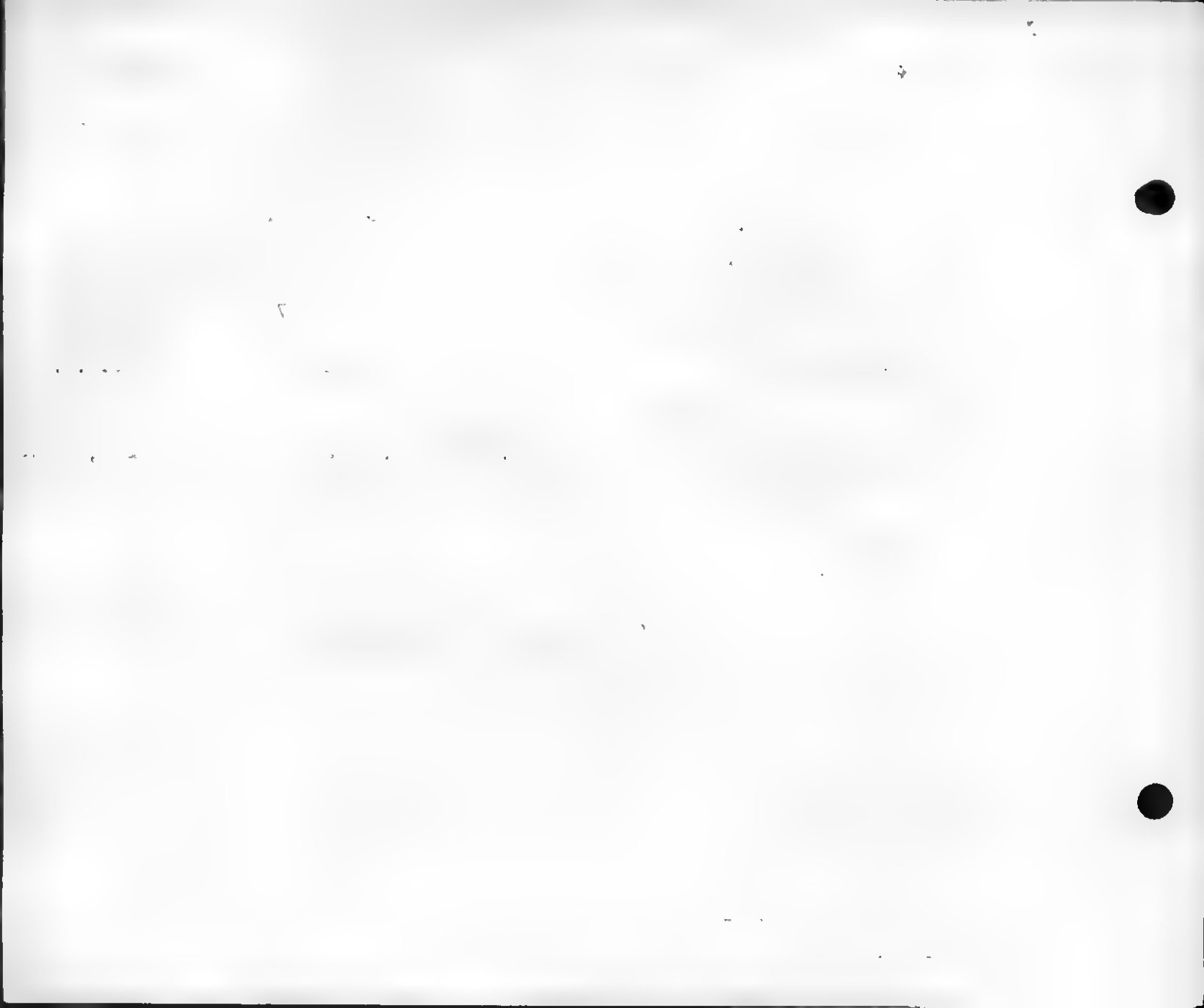
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12437

13441

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 'b Arbutus			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4749 Westland Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELEANOR MARY DUVALL				4. DATE OF DEATH Month Day Year October 12, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-4-1893	
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Kotmair				14. MOTHER'S MAIDEN NAME Rachael			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Mr. Mearle D. Duvall, 3009 Savoy Lane, Bowie Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-vascular Disease 7-7-41 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE J. N. Frederick m.d.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) J. N. Frederick m.d.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town or county) 134 Francis Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-16-67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue				25a. RECEIVED BY REGISTRAR 21229		25b. REGISTRAR'S SIGNATURE John J. Judge	
DATE OCT 16 1967							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

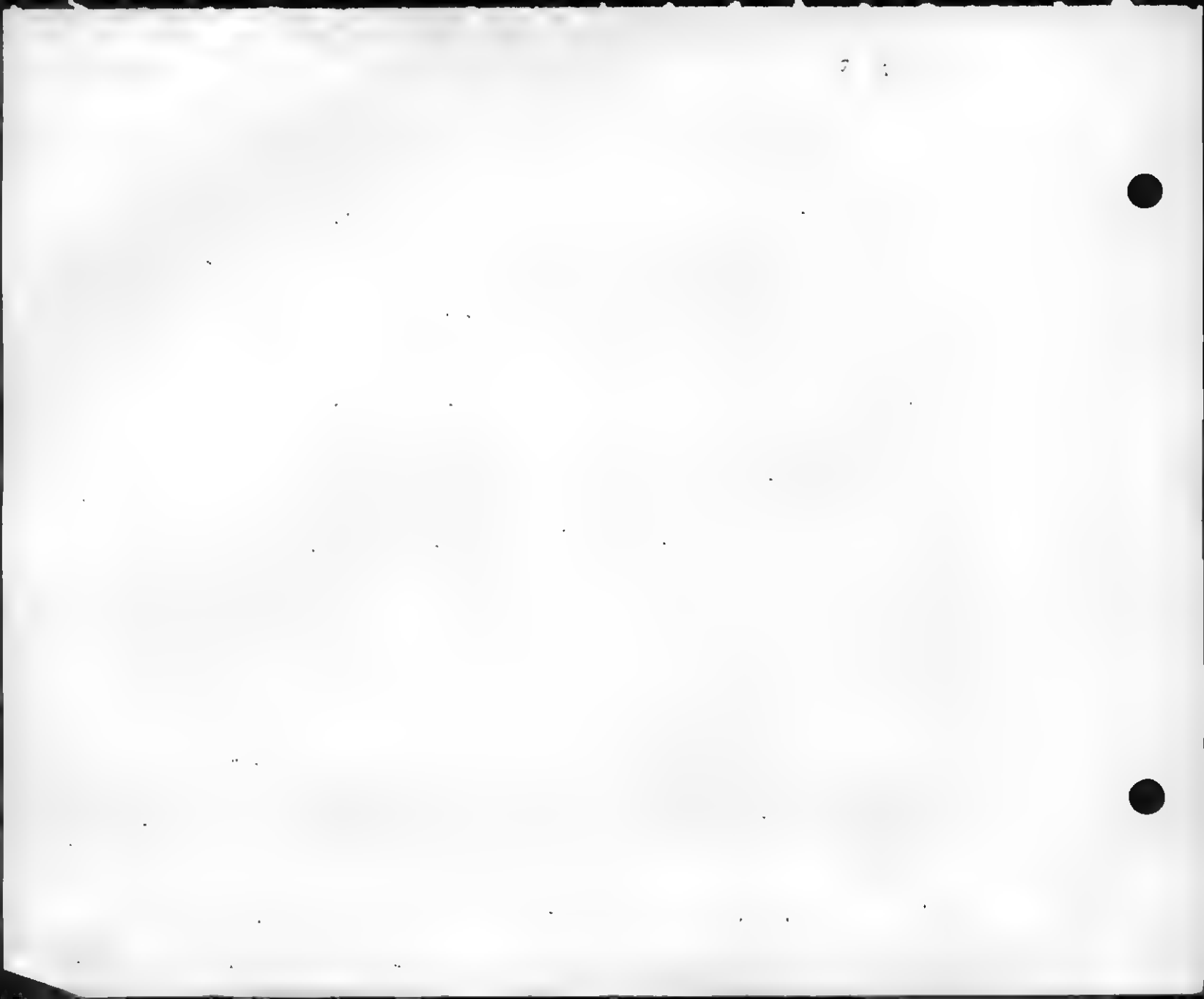
VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13442

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>or land</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pockessville</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pockessville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Box 25 Falls road</i>		e. STREET ADDRESS <i>Box 25 Falls road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Albert Joris Edwards</i>		4. DATE OF DEATH Month Day Year <i>Octo'er 23, 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 29, 1913</i>
9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>54</i> yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Charles Earl Powell</i>		14. MOTHER'S MAIDEN NAME <i>Blanche Jones Alban</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Family records</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST.</i> DUE TO (b) <i>CANCER OF THE LUNG & BRAIN METASTASIS</i> DUE TO (c) <i>Months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>seconds</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>March 29, 1967</i> , to <i>October 23, 1967</i> , that (I) (we) last saw the deceased alive on <i>October 23, 1967</i> , and that death occurred at <i>10:20 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Guillermo I. Gonzalez</i>		22b. DATE SIGNED <i>October 24/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>GUILLERMO I. GONZALEZ MD</i>		22d. ADDRESS <i>10634 York Rd. Pockessville Md. 21050</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE THEREOF <i>Oct. 26, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Valley Memorial</i>	23d. LOCATION (City, town or county) (State) <i>Pockessville, Maryland</i>
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR <i>ACT 27 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT

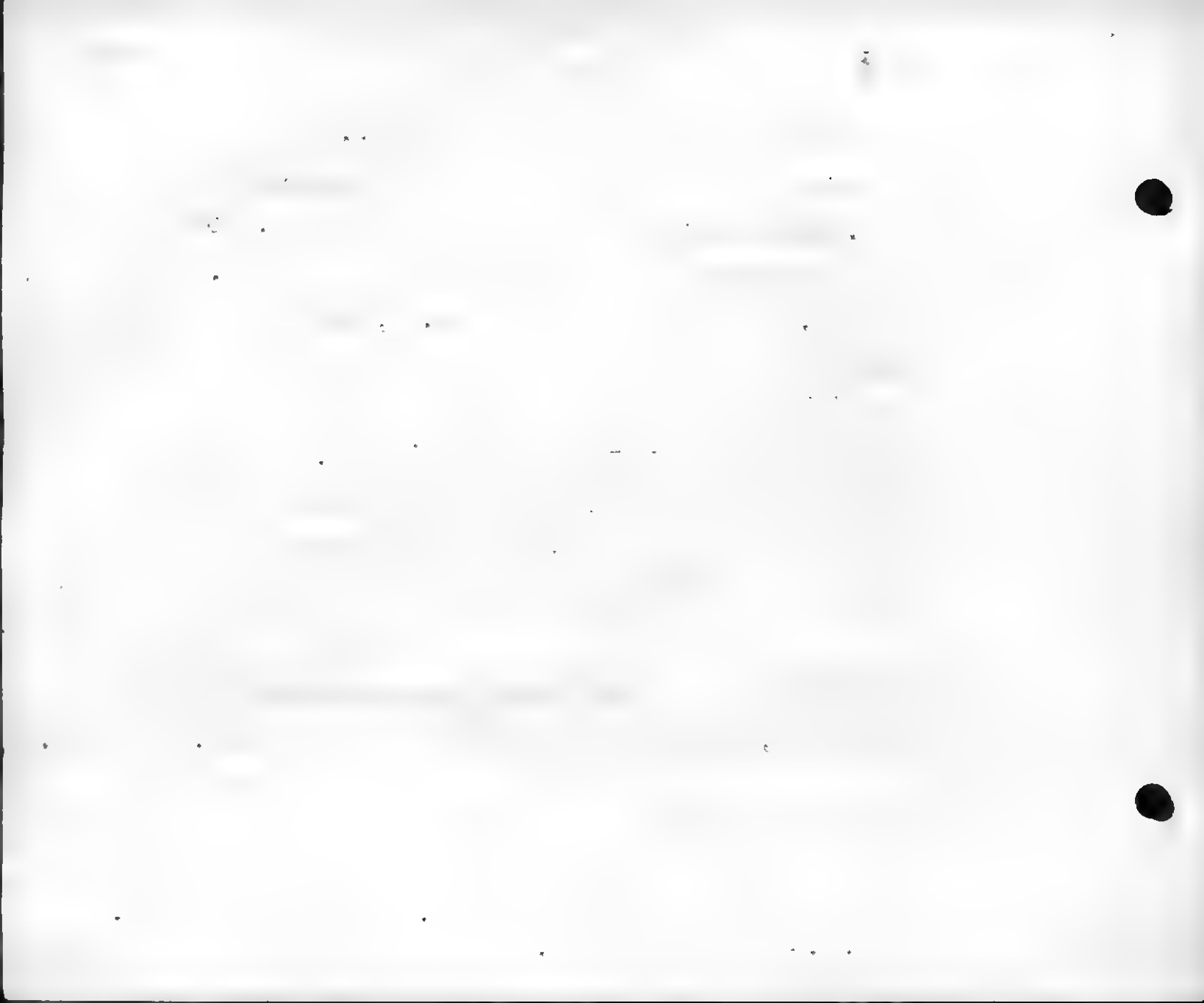
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13443

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Md. b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital				e STREET ADDRESS 5940 Sunset Ave. 21207			
3 NAME OF DECEASED (Type or print) Rosario ELARDO				4 DATE OF DEATH Month Oct. Day 14 Year 19 67			
5 SEX Male	6 COLOR OR RACE W.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1885 Nov. 18, 1885		9 AGE (In years last birthday) 83 81 yrs	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Italy		12 CITIZEN OF WHAT COUNTRY? ITALY	
13 FATHER'S NAME				14 MOTHER'S MAIDEN NAME			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 218-10-1226A		17 INFORMANT Harry R. Elardo 5940 Sunset Ave. - 21207		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Coughed Pneumonia DUE TO (b) Fractured Femur DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 Days 8 Days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fall at home in apparent confusion			
20c TIME OF INJURY Month, Day, Year Hour, a.m. (p.m.) Oct 5, 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home		20f (City or town) (County) (State) Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street city, town or county)			
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 10/18/67		23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.				25a REC'D BY REGISTRAR OCT 17 1967		25b REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

16

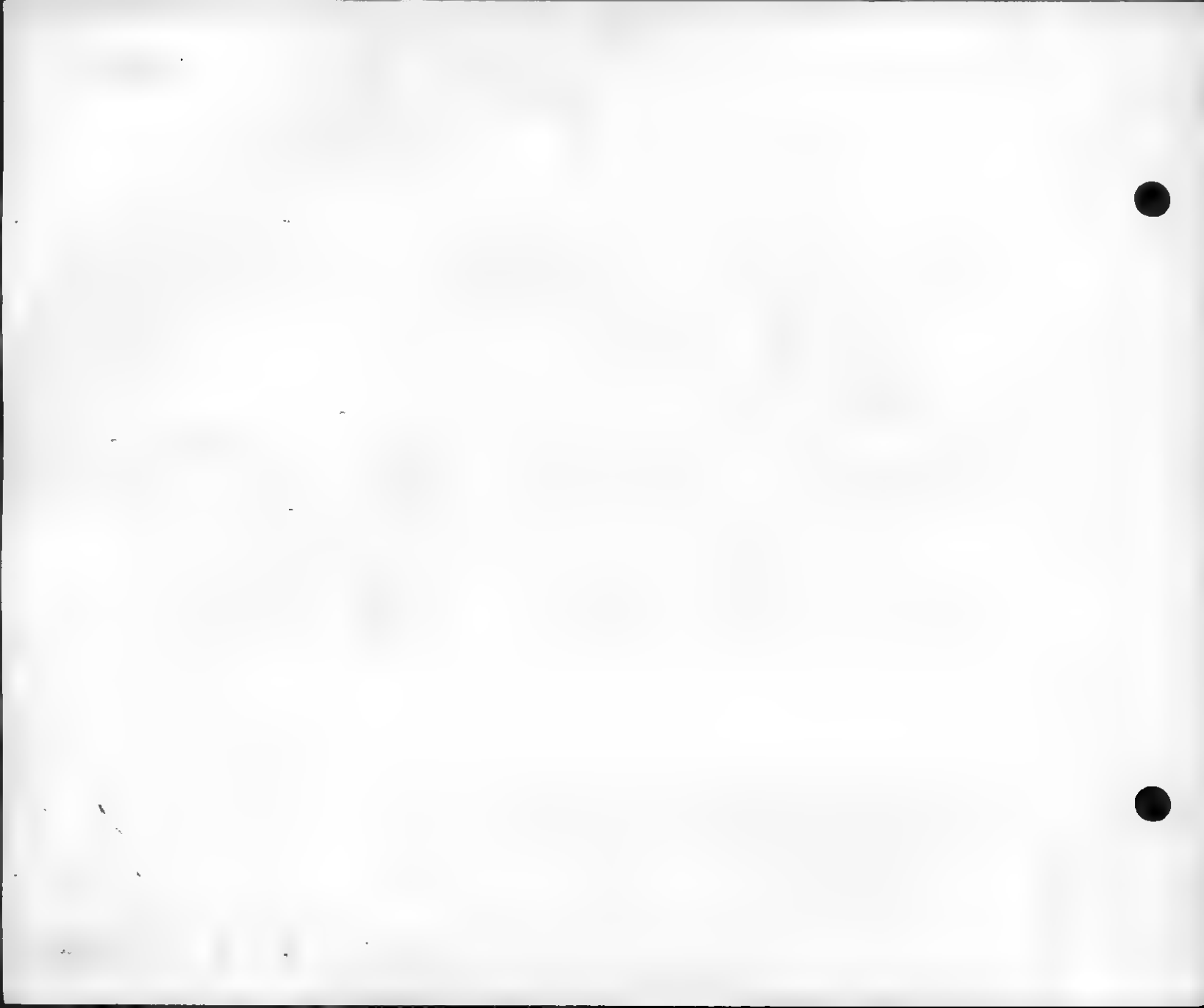
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13444

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY -			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital (D.O.A.)				e STREET ADDRESS 601 E. 41st St.			
3. NAME OF DECEASED (Type or print) Miss Agnes C Engers				4 DATE OF DEATH October 18 1967			
5 SEX Female		6 CO. OR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 9/20/1890	
9 AGE (In years last birthday) 77		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress -Ret.		10b KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles Engers			
14. MOTHER'S MAIDEN NAME Anna Gier				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No			
16 SOCIAL SECURITY NO 216 24 0622				17 INFORMANT John A. Engers- Address 288 Bloomsbury Ave. Balto., Md. 21228			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Ischemic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Heart				INTERVAL BETWEEN ONSET AND DEATH 10/18/67			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 10/18/67				23a BURIAL CREMATION, REMOVAL (Specify) Burial			
23b DATE THEREOF 10/21/67				23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.			
23d LOCATION (City or town) (County) (State) Baltimore, Maryland				24 FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #1			
25a REC'D BY REGISTRAR OCT 19 1967				25b REGISTRAR'S SIGNATURE Charles Judge			

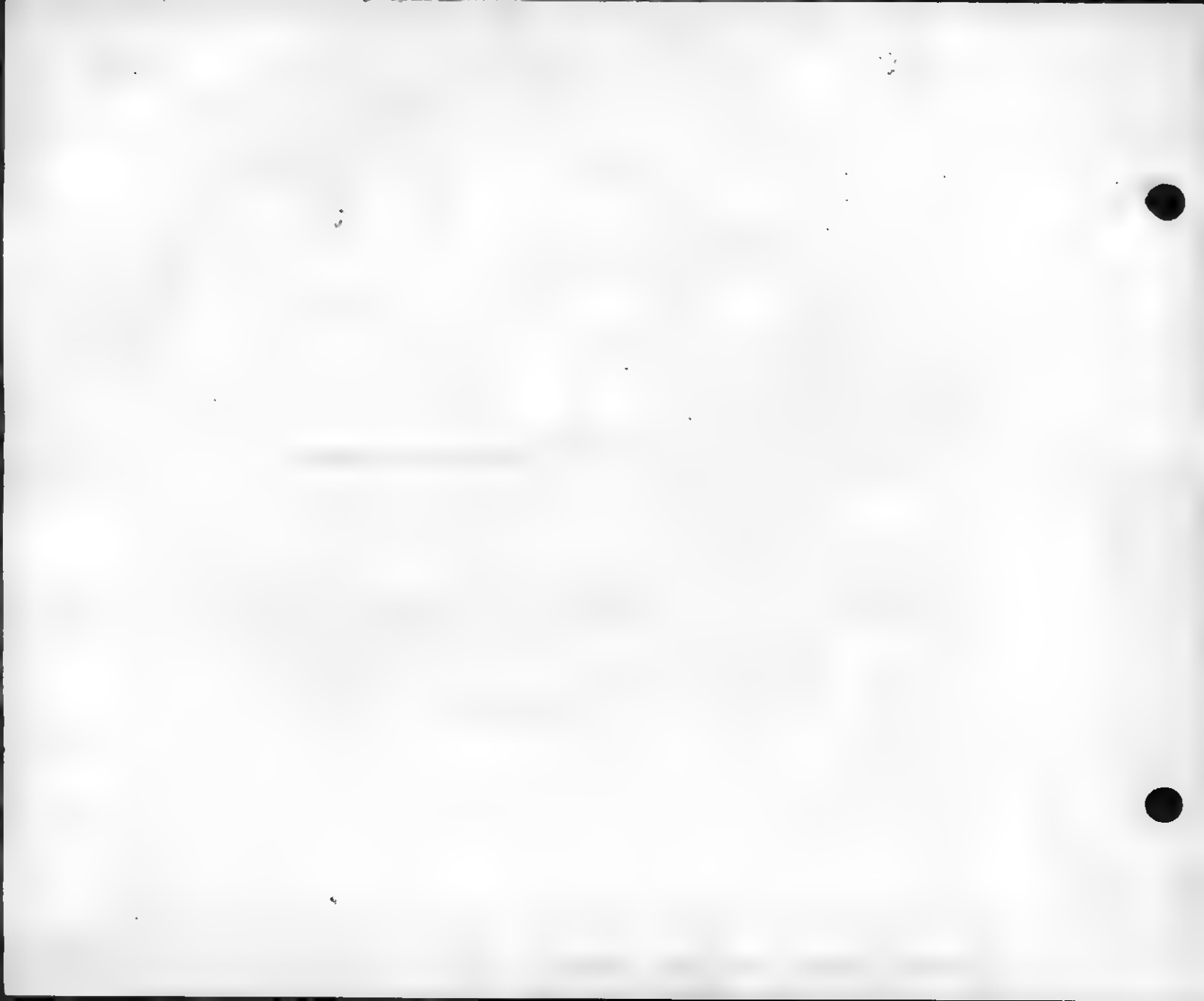


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME
350D 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Carmel Rd.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u> d. STREET ADDRESS <u>York Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MARION BENJAMIN ENSOR</u>			First Middle Last		4. DATE OF DEATH <u>Oct. 23</u>		Day Year <u>19 67</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1902</u>		9. AGE (In years last birthday) <u>65</u> Yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William S. Ensor</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Hollingshead</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>213-28-6247</u>		17. INFORMANT <u>Charles W Ensor</u> Address <u>Parkton, Md. - 21120</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE TRAUMATIC INJURIES</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Mobile injury</u>					
20c. TIME OF INJURY Month, Day, Year <u>10</u> Hour a.m. <u>10/23</u> 19 <u>67</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>BALTO. MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>G. M. France</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>10/23/67</u>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stablers Cemetery</u>		23d. LOCATION (city, town or county) (State) <u>Parkton, Md.</u>			
24. FUNERAL DIRECTOR <u>Jacob Hertenstein, New Freedom, Pa.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>OCT 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13642

13446

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GATHISON</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FOXLEIGH Nursing Home</u>				d. STREET ADDRESS <u>1705 HINES LANE</u>			
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>S</u> Last <u>EVANS</u>				4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-1900</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ennice, N.C. Moex</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			
13. FATHER'S NAME <u>John Tompkins</u>				14. MOTHER'S MAIDEN NAME <u>Bid Sue Whittaker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>239-18-9077B2</u>		17. INFORMANT <u>Town Evans, Rt. 2, Darlington, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 551X DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u> hours	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident August 1967</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-11</u> , 19 <u>67</u> , to <u>10-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-22</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>David I. Miller</u> M.D.				22b. DATE SIGNED <u>10-22-67</u>		22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>	
22d. ADDRESS <u>Lisbon Rd. - Cowing Mills, Md</u>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Oct. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reins-Sturdivant F.H.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sparta N.C.</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13448

13447

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore #21213 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #21213 d. STREET ADDRESS 3136 Kenyon Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph A. FANGMAN		4. DATE OF DEATH Month Day Year October 13 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1914
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Fangman		14. MOTHER'S MAIDEN NAME Blanche ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 212-09-7156	
17. INFORMANT Mrs. Hilda R. Fangman		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of the left leg (amputated) 17 11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to the abdomen, lungs, and brain DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 26, 1967 , to October 13, 1967 , that (I) (we) last saw the deceased alive on October 13, 1967 , and that death occurred at 11:30 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Anibal Escobar</i>		22b. DATE SIGNED October 14, 1967	
22c. PHYSICIAN'S NAME (Type) Anibal Escobar, M.D.		22d. ADDRESS 7620 York Road Towson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/17/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leona rd J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE OCT 16 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

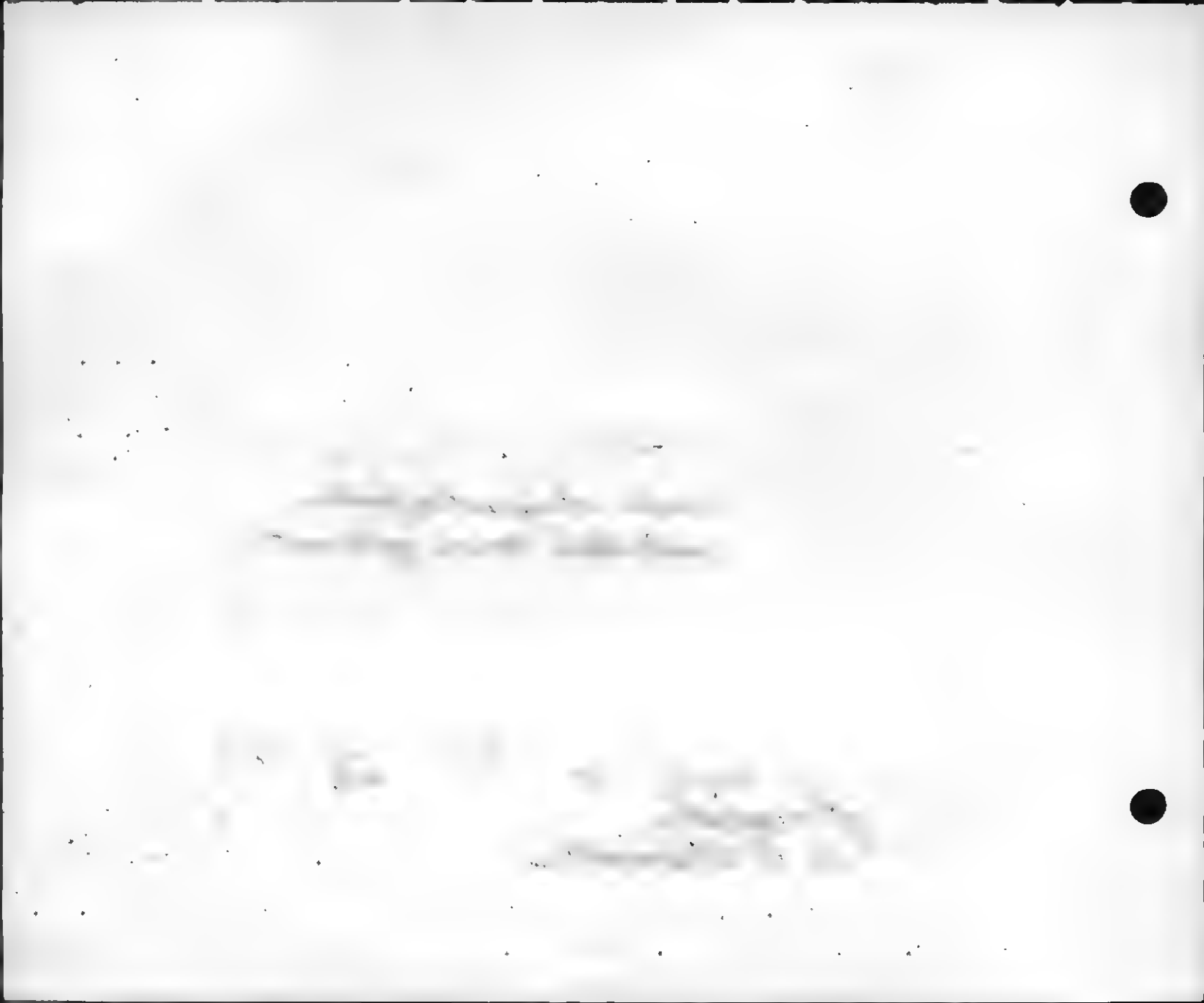


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13448
12344
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 81 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		e. STREET ADDRESS 7209 WALDMAN AVENUE	
3. NAME OF DECEASED (Type or print) MARTHA WILLIS FARRIS		4. DATE OF DEATH Month OCTOBER Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/13
9. AGE (in years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HORATIO DAWSON		14. MOTHER'S MAIDEN NAME CLARA V. DAWSON (YOUNGBLOOD)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-52-0828	
17. INFORMANT (Name) Mr. Marion Farris		Address Edgemere, Md. 7209 Waldman Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic cancer of breast DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/30 , 19 67 , to 10/18 , 19 67 , that (I) (we) last saw the deceased alive on 10/18 , 19 67 , and that death occurred at 6:45 M, from the causes and on the date stated above.			
22a. SIGNATURE P. Nandip		22b. DATE SIGNED 10/18/67	
22c. PHYSICIAN'S NAME (Type) P. Nandip		22d. ADDRESS Greater Balto. Medical Center, Towson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Mount Nebo Cemetery	23d. LOCATION (City, town or county) (State) Berkeley Springs, W. Va.
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR OCT 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

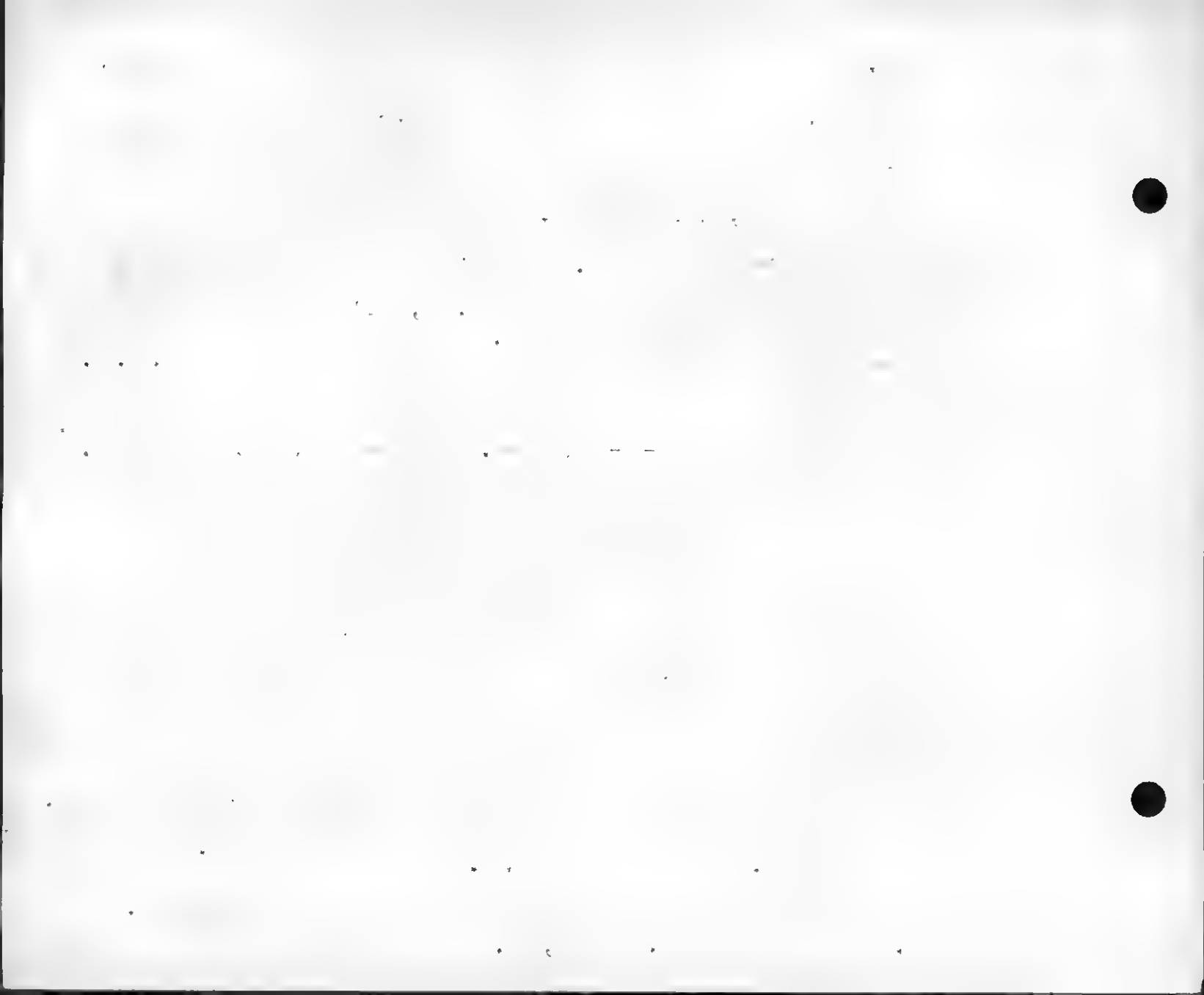
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13449

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c LENGTH OF STAY In Hours ?	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lynch Cove Marina, 1915 Wills Rd.		d STREET ADDRESS 7739 Wynbrook Road	
3 NAME OF DECEASED (Type or print) First John Middle H. Last Fink		4 DATE OF DEATH Month October Day 28 Year 19 67	
5 SEX Male	6. CO. OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 27, 1921
9 AGE (in years last birthday) 46		10 IF UNDER 1 YEAR Months 12 Days 19 Hours 67	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Co. Western Stevedoring Maryland	
11 BIRTHPLACE (State or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME ? Fink		14 MOTHER'S M A D E N NAME Ruth Turner	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO 213-16-5807	
17 INFORMANT (Name) Mrs. Catherine Fink, 7739 Wynbrook Rd.		Address Dundalk, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 176X IMMEDIATE CAUSE (a) Gun shot wound, Thru Anterior Head (left to right) c DUE TO (b) 25 cal pistol DUE TO (c) 25 cal pistol Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in head	
20c. TIME OF INJURY Month Oct Day 27 Year 1967	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boat	20f. (City or town) (County) (State) Lynch Cove - Balt. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		M D	
EXAMINER'S NAME (Type) Melvin B. Davis		M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	
25a. REC'D BY REGISTRAR OCT 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



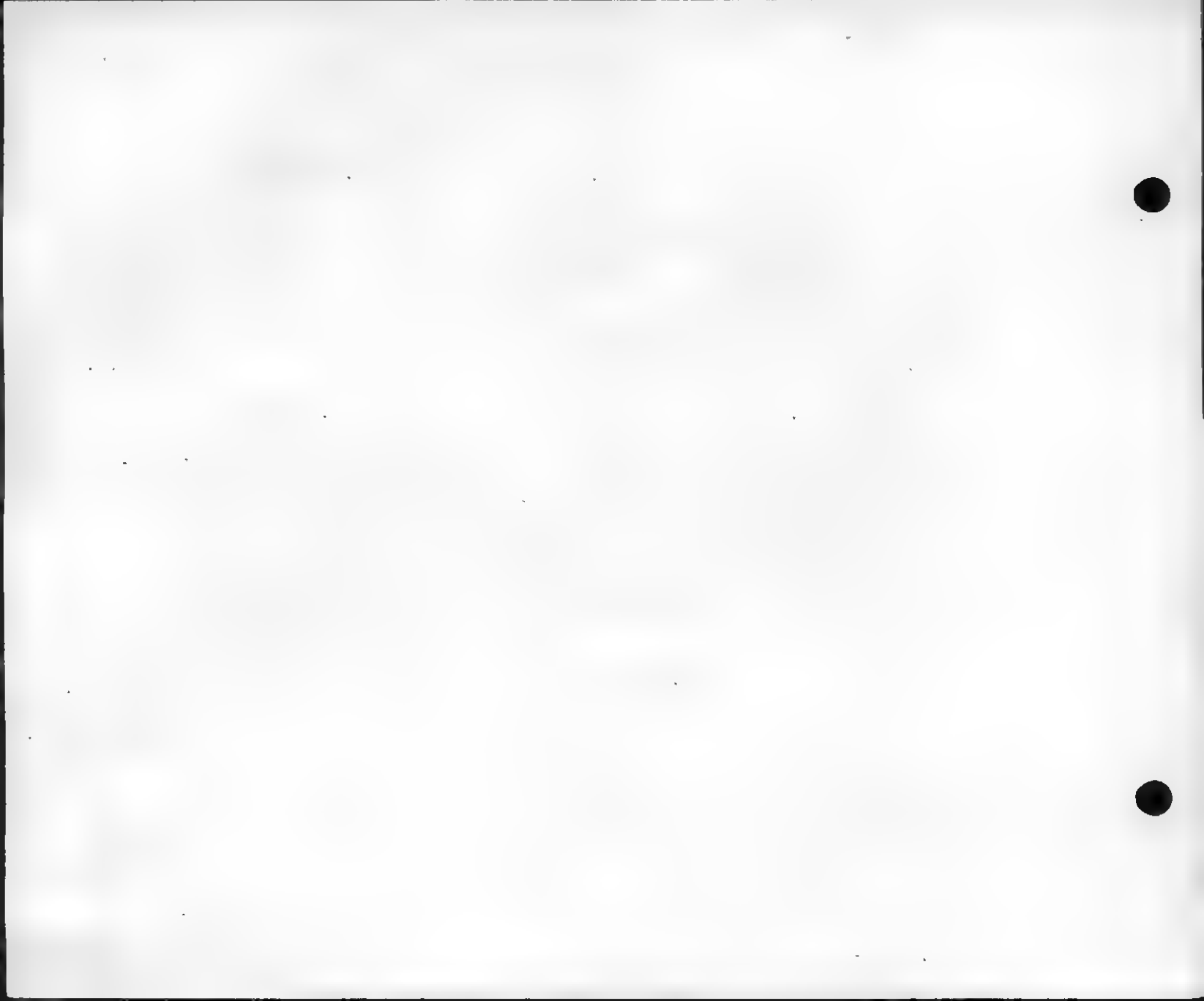
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (D)
6M 7/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland b. COUNTY D				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton			c LENGTH OF STAY IN 1b Yrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carroll Rd., Monkton				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Falls Road at Pipeline					d STREET ADDRESS Pechenial Farms			e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First THOMAS Middle EDWARD Last FINNERTY					4 DATE OF DEATH Month October Day 20 , 19 67				
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4-3-1943		9 AGE (In years last birthday) 23 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Baltimore			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME Thomas C. Finnerty					14 MOTHER'S MAIDEN NAME Lorraine M. Barron Barron				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO		17 INFORMANT Address Edward A. Barron, 107 Osborne Ave. 21228				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Cerebrospinal Injuries 214 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of motorcycle spun around and crashed into ditch						
20c TIME OF INJURY Month, Day, Year 6:10 XXXX 10/20 1967			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f (City or town) (County) (State) Baltimore, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Werner U. Spitz, M.D.			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 10/21/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE THEREOF 10-24-67		23c NAME OF CEMETERY OR CREMATORY Holy Rosary		23d LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Towson, Md.					25a REC'D BY REGISTRAR DATE OCT 26 1967		25b REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

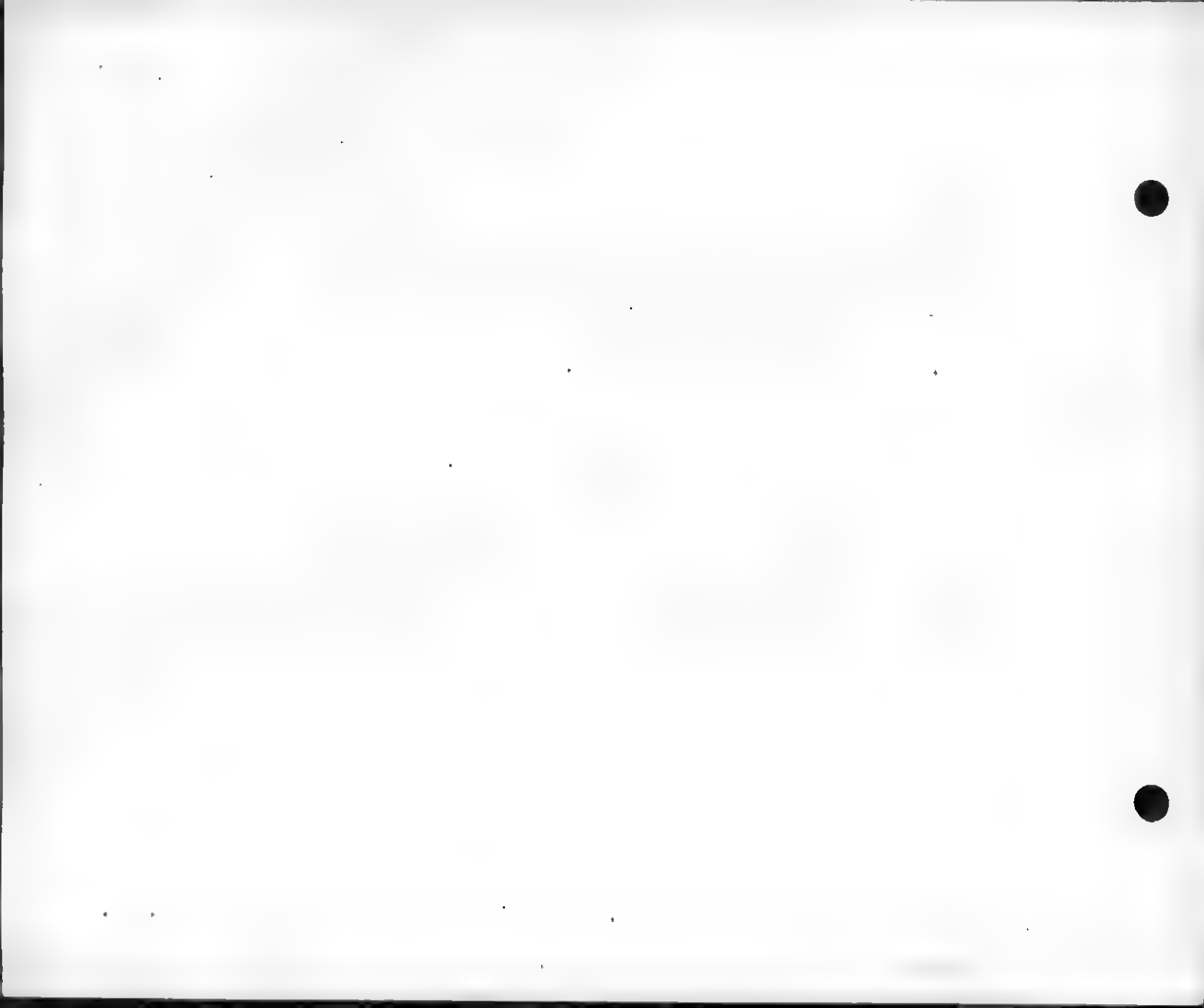
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13451

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton (Baltimore)</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton - Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7611 Fitch Lane 21236</u>				d. STREET ADDRESS <u>7611 Fitch Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Edward</u> Last <u>Fitch</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. CO. OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14, 1878</u>	9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOHN B. Fitch</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Sipple</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-5456</u>		17. INFORMANT <u>Mary E. Fitch 7611 Fitch Lane</u>		Address <u>21236</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Other sclerotic Cardio Vascular Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN DEATH AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus & Anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <u>John C. Hyle</u>		22. DATE SIGNED <u>10-5-67</u>		22. DEPUTY MEDICAL EXAMINER Address (Street city town, or county) <u>7577 Belair Rd. 36.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/9/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Fullerton Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

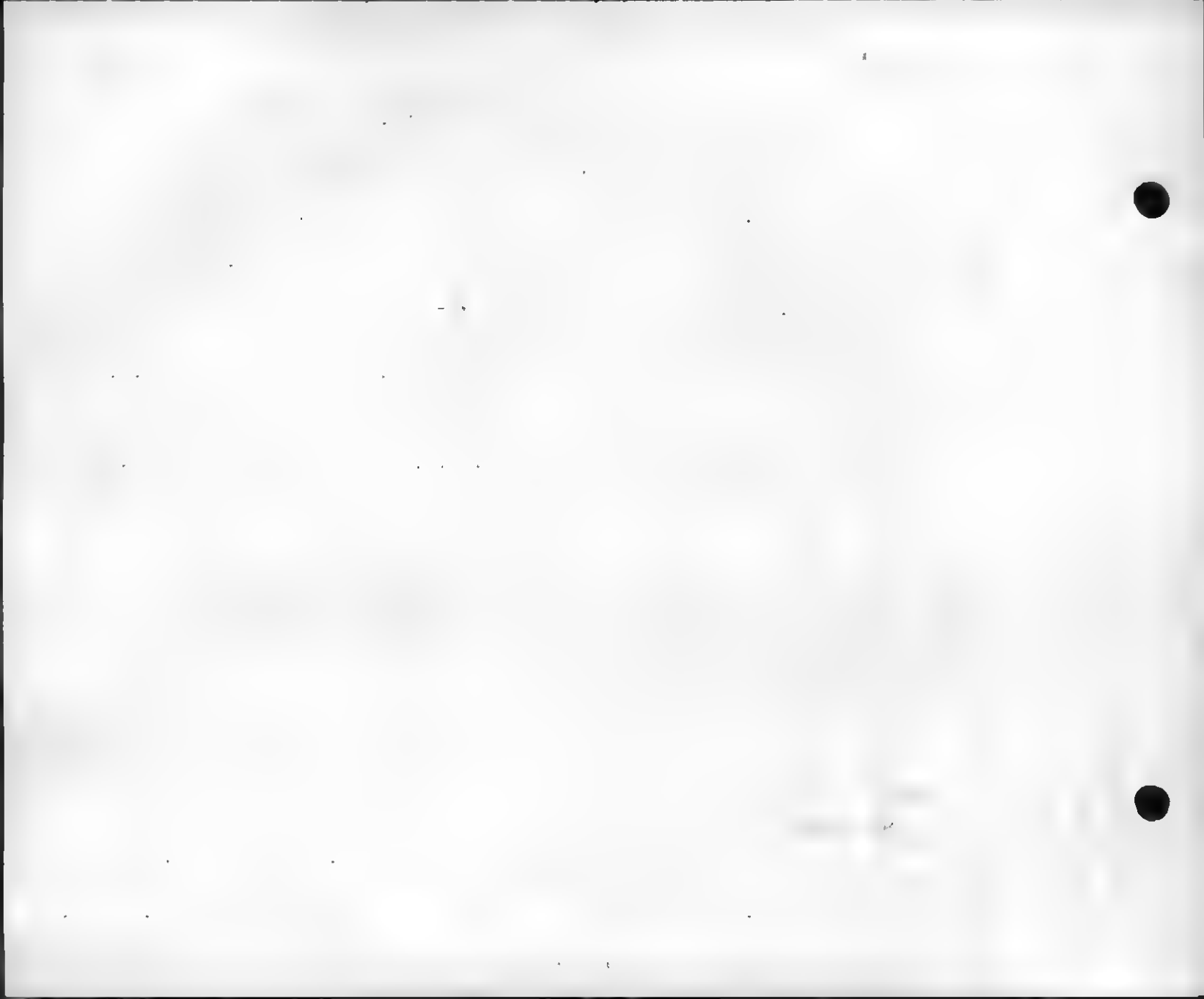
13448

CERTIFICATE OF DEATH

13452

1 PLACE OF DEATH a. COUNTY Baltimore <div style="text-align: right;">MARYLAND</div>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 15 yrs. Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1802 Clermont Ct.		e. STREET ADDRESS 1802 Clermont Ct.	
3 NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last Marie Pauline Flesher</div>		4. DATE OF DEATH <div style="text-align: center;">Month Day Year Oct. 30, 67 19</div>	
5 SEX F	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-7-1883
9 AGE (In years most birthday) 84 yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Leon Michails		14 MOTHER'S MAIDEN NAME Martha VonBushnar	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. No	
17 INFORMANT Address Dr. E.E.Flesher, Lutherville, Md. 21093			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis SSAX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic, generalized arteriosclerosis DUE TO (c) cerebral edema			INTERVAL BETWEEN ONSET AND DEATH 3 mos. 2 mos. 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arteriosclerotic cardio vascular disease			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from March 7, 1964 , to October 30, 1967 , that (2) we last saw the deceased alive on October 28, 1967 and that death occurred at 3:15 AM , from causes and on the date stated above.			
22a SIGNATURE Donald O. Wood		22b. DATE SIGNED 10-30-67	
22c. PHYSICIAN'S NAME (Type) Donald O. Wood, M.D.		22d ADDRESS York Rd. Timonium, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b DATE THEREOF Nov. 1, 67	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d LOCATION (City or Town) (County) (State) Cockeysville, Md. Balto.	
24 FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Towson, Md. 21204		25a REC'D BY REGISTRAR DATE NOV 2 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



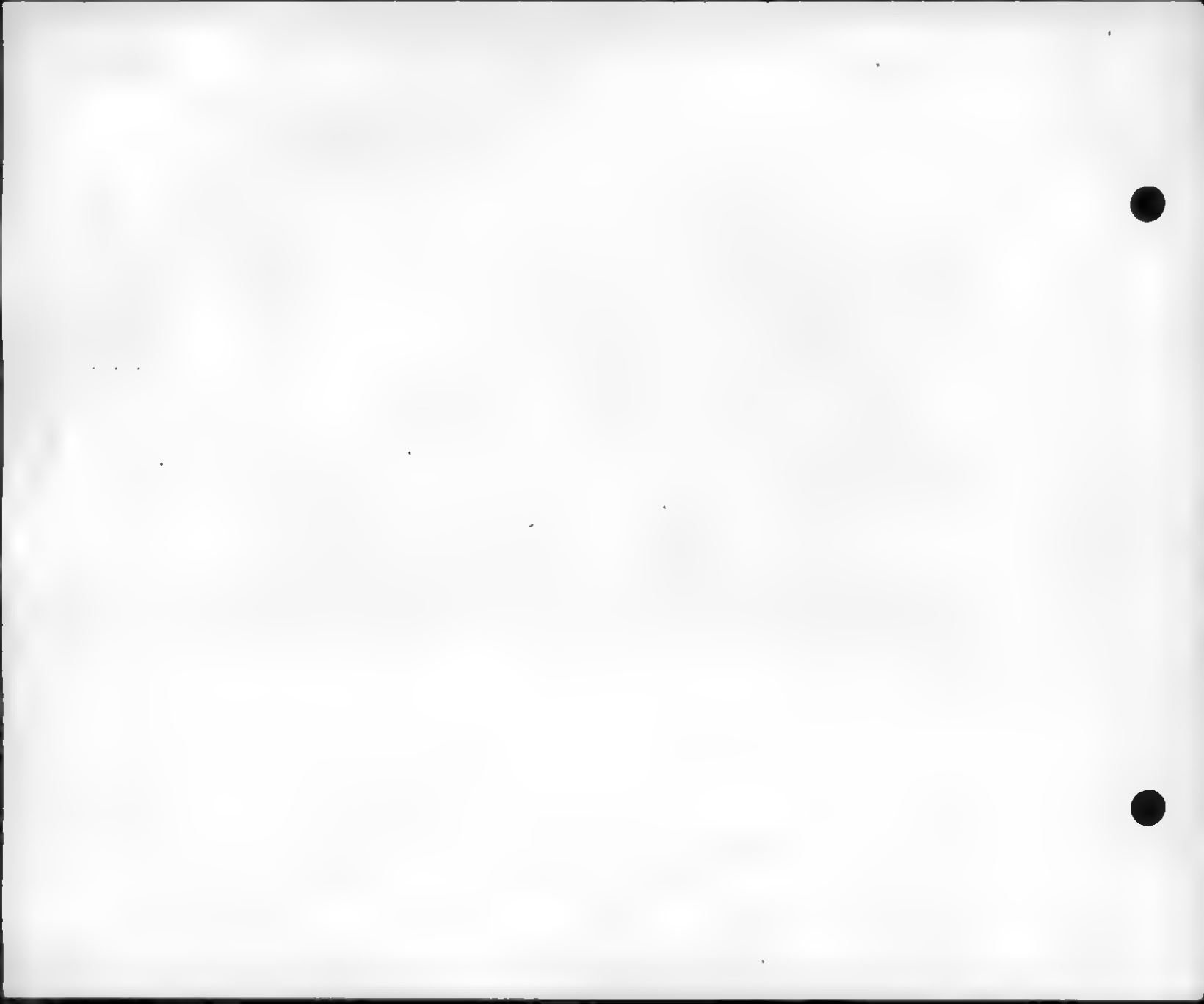
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13453

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MILFORD MANOR NURSING HOME</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4023 NORFOLK AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>RACHEL</u> <u>FLOM</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER</u> <u>5</u> , 19 <u>67</u> 8. DATE OF BIRTH 9. AGE (In years and birthday) yrs. Months Days Hours Min. <u>92</u> <u>6</u> <u>0</u> <u>0</u> <u>0</u> 11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>MORRIS FOOKSMAN</u> 14. MOTHER'S MAIDEN NAME <u>YETTA</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>MRS. HILDA LIBOV, 7121 PARK HEIGHTS AVE., APT. 304, BALTIMORE, MD.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> DUE TO <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic bronchitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u>, 19<u>64</u> to <u>Oct 5</u>, 19<u>67</u> that (I) (we) last saw the deceased alive on <u>10-2</u> 19<u>67</u>, and that death occurred at <u>1:30</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Irving Sauber</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>DR. IRVING SAUBER</u> 22d. ADDRESS <u>6905 PARK HEIGHTS AVENUE</u>				22b. DATE SIGNED <u>10-6-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SHOREVIEW MISHMERES</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13454

1 PLACE OF DEATH a. COUNTY BALTO MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT HOME		d. STREET ADDRESS 35 MELVIN AVE	
3 NAME OF DECEASED (Type or print) ALFRED M. FORT		4 DATE OF DEATH OCT. 4 1967	
5 SEX M	6 CO. OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/2/93
9 AGE (in years last birthday) 74 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENG.		10b KIND OF BUSINESS OR INDUSTRY RET.	
11 BIRTHPLACE (County & State, or foreign country) MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL J. FORT		14. MOTHER'S MAIDEN NAME WETHERBEE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16 SOCIAL SECURITY NO. 219018628	
17 INFORMANT ADELE J. FORT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of St. Lung 163 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 months 6 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Jan , 1967, to Oct 4 , 1967, that (I) (we) last saw the deceased alive on Sept 30 1967, and that death occurred at 6:10 AM , from causes and on the date stated above			
22a. SIGNATURE John A. Nesbitt Jr		22b. DATE SIGNED 10-4-67	
22c. PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR		22d. ADDRESS 1009 Frederick Rd, Baltimore Md 21228	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 10/6/67	23c NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	23d LOCATION (City or Town) (County) (State) BALTO. MD
24 FUNERAL DIRECTOR E.S. MACNABB		25a REC'D BY REGISTRAR OCT 10 1967	
ADDRESS 301 FREDERICK RD 21228		25b REGISTRAR'S SIGNATURE Charles Judge	

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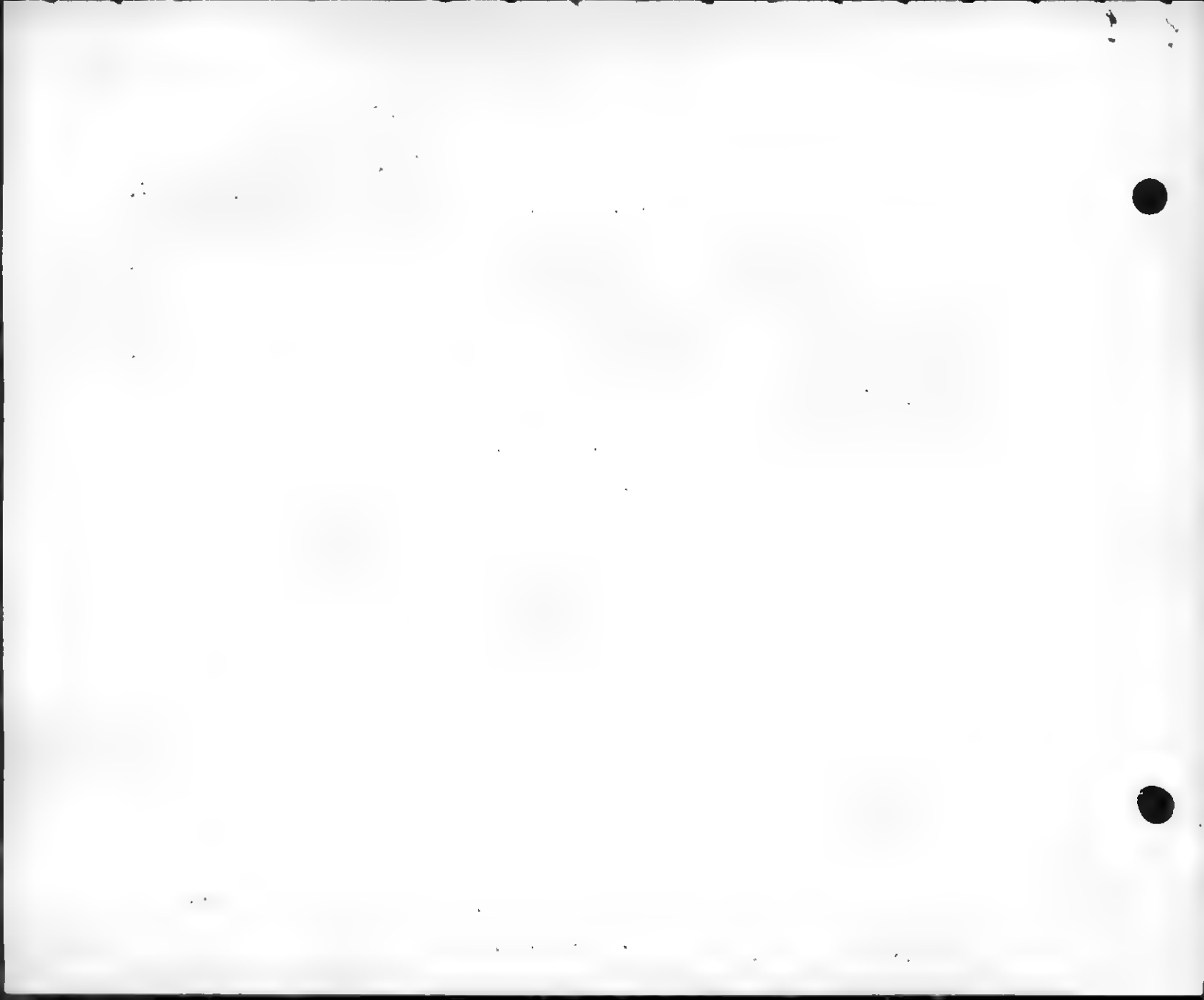


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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13455
Item #9 Film #393-10/13/67 ph

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> c. LENGTH OF STAY IN 1b <u>61 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> d. STREET ADDRESS <u>130 SLADE AVENUE, APT. 407</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>ZELICK</u> Last <u>FRAHM</u>		4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-1891</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> IF UNDER 24 HRS. Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHINERY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED LEWIS FRAHM</u>		14. MOTHER'S MAIDEN NAME <u>SARAH</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-09-8648B</u>	
17. INFORMANT <u>MRS. YETTA FRAHM, 130 SLADE AVE., APT. 407</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular insult.</u> 47 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinsonism, Gaucher's Dis.</u> (c) <u>ASHD, Cat bladder kidney inf.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8</u> , 19 <u>62</u> , to <u>10/5</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>62</u> , and that death occurred at <u>2:45</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Leonard M. Lister M.D.</u>		22b. DATE SIGNED <u>10/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leonard M. Lister M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-8-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MENS</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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1 and 2
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12152

13157

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Nursing Home		d. STREET ADDRESS 102 Washington Street	
3. NAME OF DECEASED (Type or print) First HENRY Middle H. Last FREEMAN SR.		4. DATE OF DEATH Month OCT. Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1874
9. AGE (In years lost birthday) 93 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXXXXXXXX John F. Freeman		14. MOTHER'S MAIDEN NAME Christina Henft	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Spanish-American War		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Ira L. Freeman		Address Same as 2 D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic Cardio Vasc. Disease - 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 26, 1967 , to OCT 3, 1967 , that (I) (we) last saw the deceased alive on OCT 2, 1967 , and that death occurred at 5:54 A.M. from causes and on the date stated above.			
22a. SIGNATURE HARRY L. KNIPP, M.D.		22b. DATE SIGNED 10-3-67	
22c. PHYSICIAN'S NAME (Type) HARRY L. KNIPP, M.D.		22d. ADDRESS 4116 Edmonson Ave. Balt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-6-67	
23c. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.		25a. REC'D BY REGISTRAR OCT 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3453

CERTIFICATE OF DEATH

13458

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY in lb <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill Nursing Home</u>				d. STREET ADDRESS <u>3525 Meadowside Rd #7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JESSIE C. FREY</u>				4 DATE OF DEATH Month <u>10</u> - Day <u>6</u> Year <u>1967</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <u>7-2-1903</u>	
9 AGE (In years last birthday) <u>64</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Paper Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lancaster, Pa.</u>	
13. FATHER'S NAME <u>Jacob Frey</u>				14. MOTHER'S MAIDEN NAME <u>Bitzberger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO <u>212-07-4381</u>		17. INFORMANT <u>J. Catherine Bishop - 6111 Bellona Ave #12</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency, Emphysema</u> DUE TO (b) <u>Cor Pulmonale, Progressive</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1967</u> , to <u>Oct 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 5, 1967</u> , and that death occurred at <u>3p</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Daniel Bakal</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-6-67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24 FUNERAL DIRECTOR <u>Elkworth Armagost - 4600 Liberty Hgts</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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13254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13459

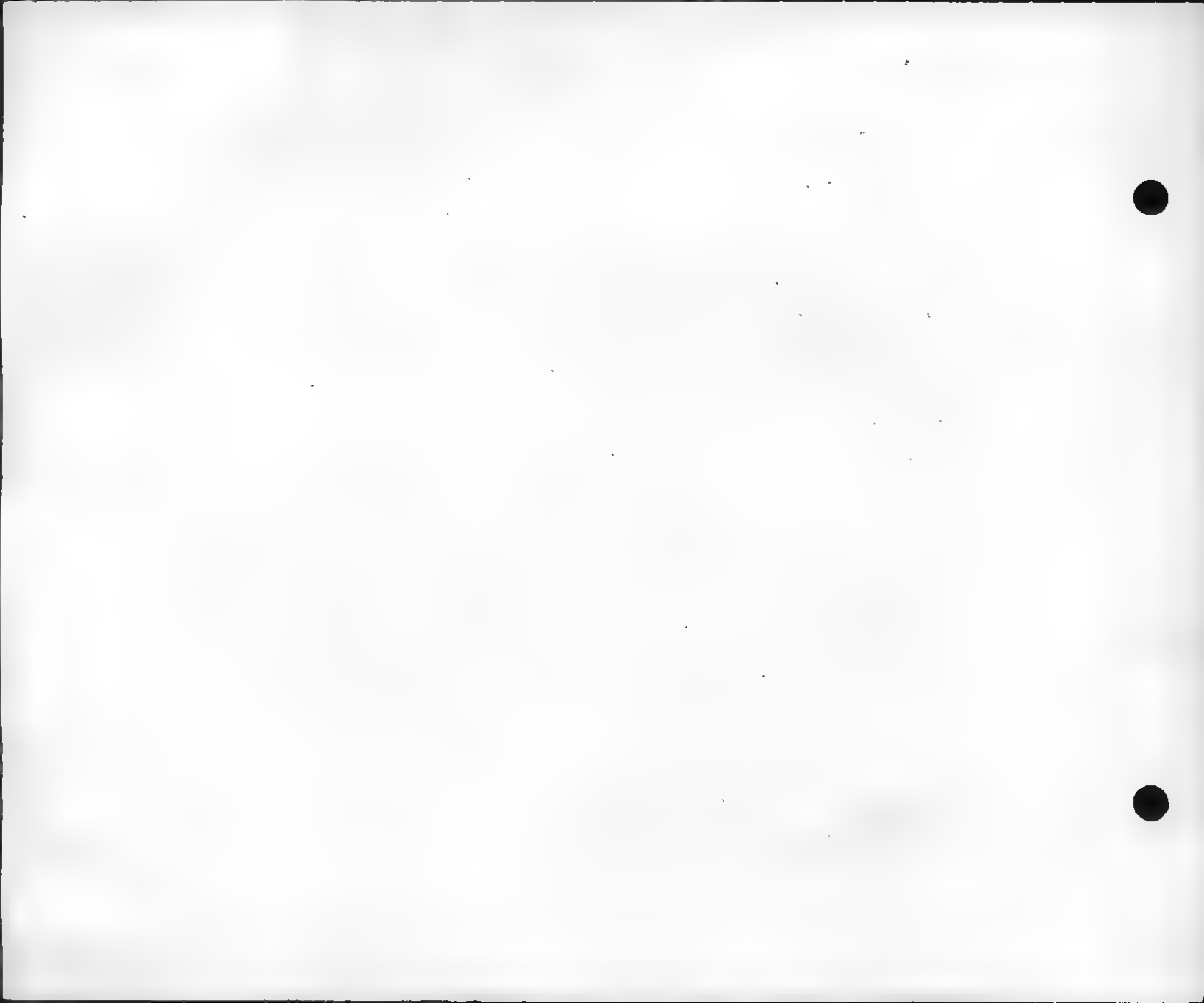
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY BALTO MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MD. b COUNTY BALTO.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 FIR DR.		d STREET ADDRESS 7 FIR DR.	
3 NAME OF DECEASED (Type or print) EVERETT M. FRIEND		4 DATE OF DEATH Month OCT. Day 20 Year 1967	
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 19, 1904 62 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY BANK	9 AGE (In years last birthday) 62 yrs
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPHUS FRIEND		14. MOTHER'S MAIDEN NAME RUBY FRIEND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214-01-9254	
17. INFORMANT RUBY FRIEND		Address 7 FIR DR.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion +201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theo C. Patterson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) THEO C. PATTERSON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/23/67	
23c. NAME OF CEMETERY OR CREMATORY STEELE		23d. LOCATION (City or Town) (County) (State) FRIENDSVILLE MD.	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS 300 MACE		25a. REC'D BY REGISTRAR OCT 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13455

13460

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 16 <u>unk</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> d. STREET ADDRESS <u>8403 Merryview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>May</u> Last <u>Feithner</u>			4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1967</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1899</u>		9 AGE (In years last birthday) <u>68</u> yrs IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto MD</u>			
13. FATHER'S NAME <u>Clayton Samuel</u> <u>John</u>			14. MOTHER'S MAIDEN NAME <u>Emma Harrison</u> <u>Mary E. Harrison</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>2-18-18-1571</u>		17. INFORMANT <u>Hosy, Chert</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u>, 19<u>66</u>, to <u>10/13</u>, 19<u>67</u>, that (I/we) last saw the deceased alive on <u>10/13</u>, 19<u>67</u>, and that death occurred at <u>11:00 AM</u>, from causes on and on the date stated above.							
22a. SIGNATURE <u>David E. Zickfoose</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>DAVID E. Zickfoose</u>			22d. ADDRESS <u>9 VFW Lane, Ellicott City, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>			
23d. LOCATION (City or Town) <u>Woodlawn</u>		(County)		(State) <u>Balto MD</u>			
24. FUNERAL DIRECTOR <u>Foring Byers</u>		ADDRESS <u>8728 Liberty Rd</u>		25a. REC'D BY REG-STRAR <u>OCT 16 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
19455					13-161						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY BALTO.			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		a. STATE MD		b. COUNTY BALTO.				
c. LENGTH OF STAY IN 1b ESSEX			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 216 WAMPLER RD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX			d. STREET ADDRESS 216 WAMPLER RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last ANNA M. GERLACH					4. DATE OF DEATH Month Day Year OCT. 23 1967						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 5, 1889		9. AGE (In years last birthday) 78 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) PENNA.			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME ROTTMUND					14. MOTHER'S MAIDEN NAME ?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. —		17. INFORMANT MILTON GERLACH				
					Address 216 WAMPLER						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident +5X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —										INTERVAL BETWEEN ONSET AND DEATH Immediate	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from 1957 to 10-23 , 1967, that (1) (we) last saw the deceased alive on 10-22 , 1967, and that death occurred at 10⁰⁰ A.M. from the causes and on the date stated above.											
22a. SIGNATURE J.B. Littleton M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-23-67				
22c. PHYSICIAN'S NAME (Type) J.B. LITTLETON MD.					22d. ADDRESS 1012 OLD NORTH PT. RD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 25, 1967		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION (City, town or county) (State) BALTO. MD.					
24. FUNERAL DIRECTOR J.G. CONNELLY SONS					ADDRESS 300 MACE		25a. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13457

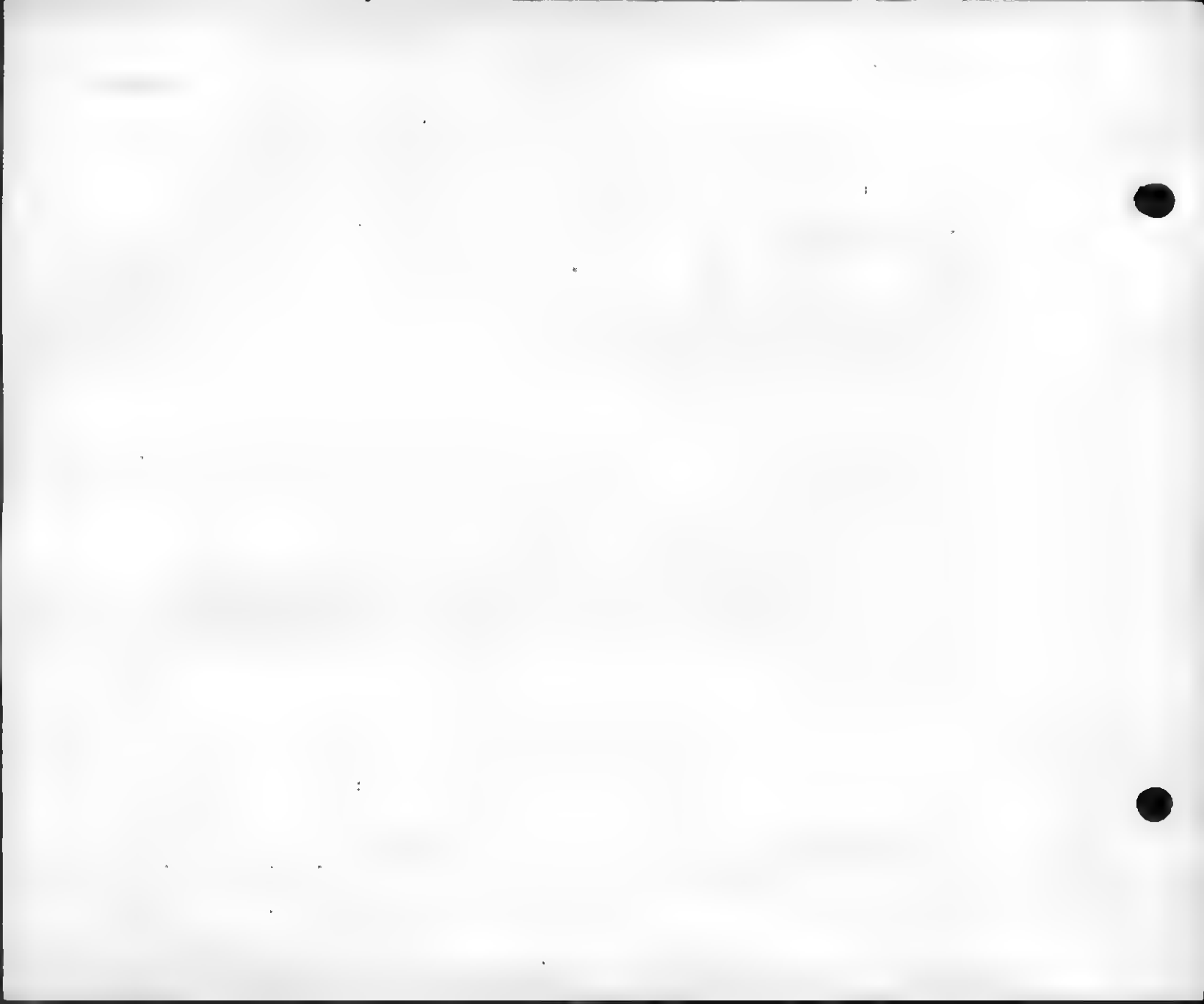
CERTIFICATE OF DEATH

13457

1. PLACE OF DEATH a. COUNTY <u>Towson</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>		d. STREET ADDRESS <u>Gore Mill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>W.</u> Last <u>Gilligan</u>		4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/21/1900</u>
9. AGE (In years last birthday) yrs. <u>67</u>		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Service Station Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. City, Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Samuel Gilligan</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Weber</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>216-20-3555</u>		17. INFORMANT Address <u>Mrs. Margaret Ward Freeland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4001</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>coronary thrombosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____ _____ _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____ _____ _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ _____	20f. (City or town) (County) (State) _____ _____ _____
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10/18</u> , 19 <u>67</u> , to <u>10/22</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>10/22</u> , 19 <u>67</u> , and that death occurred at <u>6:10 p.m.</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>William</u>		22b. DATE SIGNED <u>11/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thos. Gilliani, M.D.</u>		22d. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Falls Road Chapel</u>	23d. LOCATION (City or Town) (County) (State) <u>Butler, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		25c. REGISTRAR'S SIGNATURE _____ _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

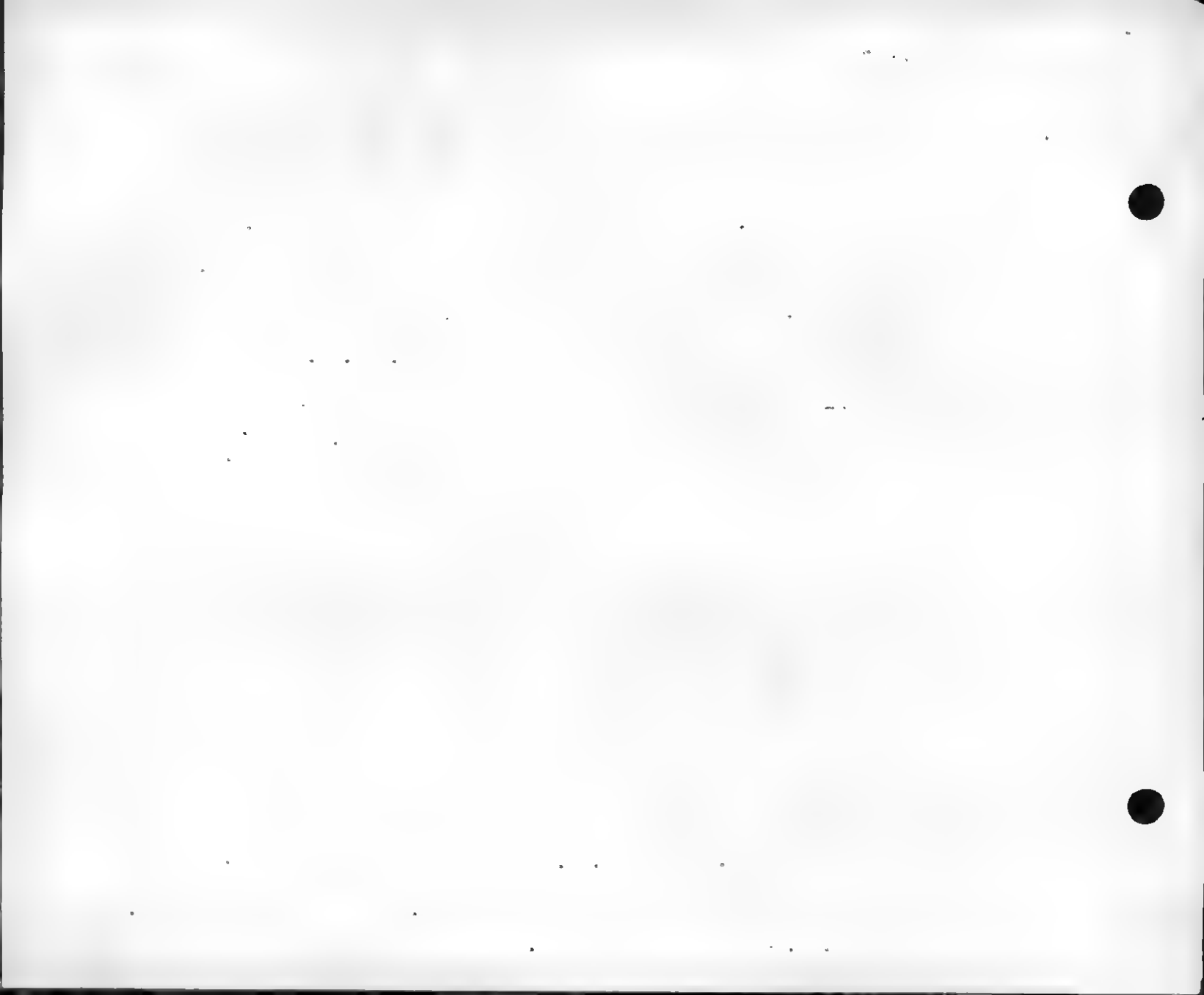
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12458

CERTIFICATE OF DEATH

13463

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 Ingleside Ave.				e. STREET ADDRESS 308 Ingleside Ave.			
3 NAME OF DECEASED (Type or print) Nellie Agnes Gladmon				4 DATE OF DEATH Month Oct. Day 2 Year 19 67			
5 SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/11/70	9 AGE (In years last birthday) 96 yrs	IF UNDER 24 HRS Months Days Hours Min.		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wash., D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME --- Hawkshaw				14. MOTHER'S MAIDEN NAME ---			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17 INFORMANT Mr. Temple L. Gladmon Address 4516 Old Frederick Rd. - 21229			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 420: IMMEDIATE CAUSE (a) Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/22 , 19 65 , to 10/2 , 19 67 that (I) (we) last saw the deceased alive on 10/2 , 19 67 , and that death occurred at 19 M. from causes and on the date stated above.							
22a SIGNATURE Robert A. Reiter				22b DATE SIGNED 10/2/67		22c PHYSICIAN'S NAME (Type) Robert A. Reiter, M. D.	
22d ADDRESS 606 Edmondson Ave. - 21228							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/5/67		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d LOCATION (City or town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.				25a REC'D BY REGISTRAR DATE OCT 4 1967			
				25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



1
FOR STATE
HEALTH DEPT

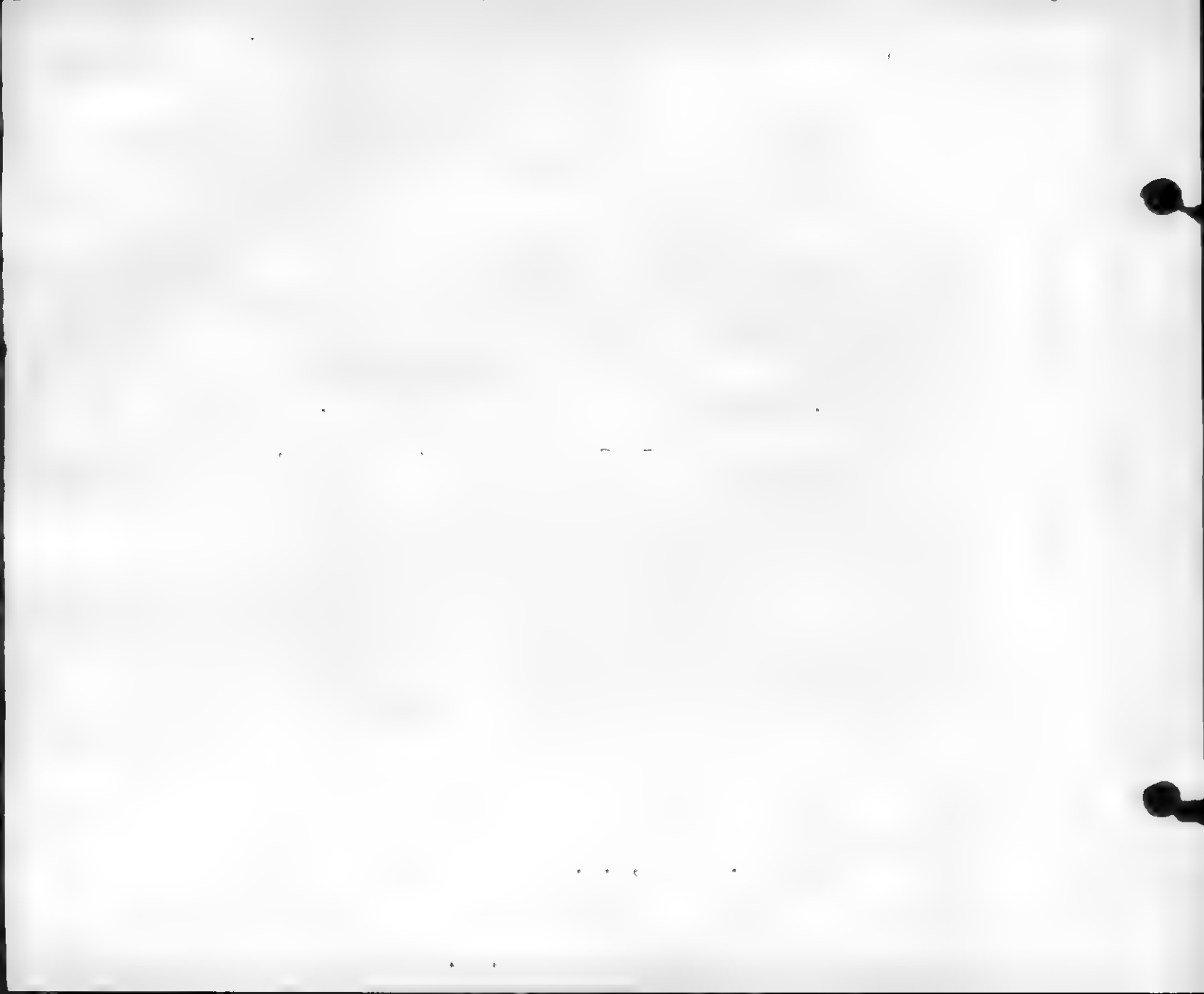
TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 13 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 62 Willow Spring Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 21222 d. STREET ADDRESS 62 Willow Spring Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRANK MUNROE GONGLOFF First Middle Last					4. DATE OF DEATH October 9th 1967 Month Day Year				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/4/1921		9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender				10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton O. Gongloff					14. MOTHER'S MAIDEN NAME Lilly F. Jenkins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 176-16-0300		17. INFORMANT Helen R. Gongloff, same as #2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>M. B. Davis</i> M.D. EXAMINER'S NAME (Type) Melvin B. Davis, M.D.					22. DATE SIGNED 10/10/67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk, Maryland Address (Street, city, town or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City, town or county) (State) A. A. Co. Md.			
24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md.					25a. REC'D BY REGISTRAR OCT 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

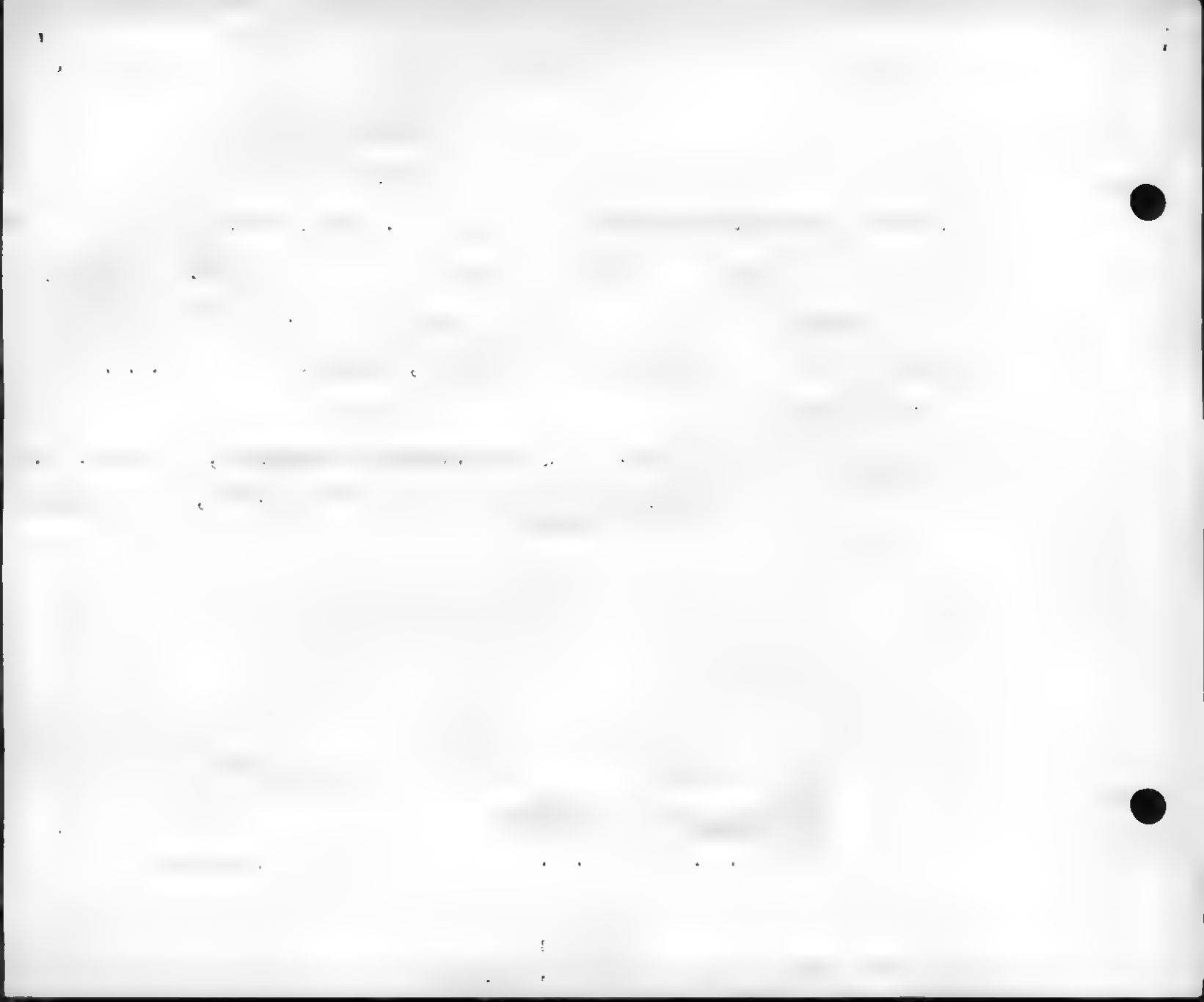
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13465

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 46 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 825 N. CAROLINE STREET	
3. NAME OF DECEASED (Type or print) First OTIS Middle PERNEL Last GOODWIN		4. DATE OF DEATH Month OCTOBER Day 31 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/1/94
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	
11. BIRTHPLACE (County & State, or foreign country) CLOVER, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GOODWIN		14. MOTHER'S MAIDEN NAME ADA CONNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 07 56 13	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH METASTASIS TO LIVER, 1000 DUE TO SKIN AND RECTUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/15/67 , 19__, to 10/31/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/31/67 , 19__, and that death occurred at 12:45 AM from causes and on the date stated above			
22a. SIGNATURE Ahmed C. K. Kutty M.D.		22b. DATE SIGNED 10/31/67	
22c. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/3/67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR B. Lock		25a. REC'D BY REGISTRAR NOV 1 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		25c. ADDRESS 13 Central Ave Baltimore, Maryland	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13466

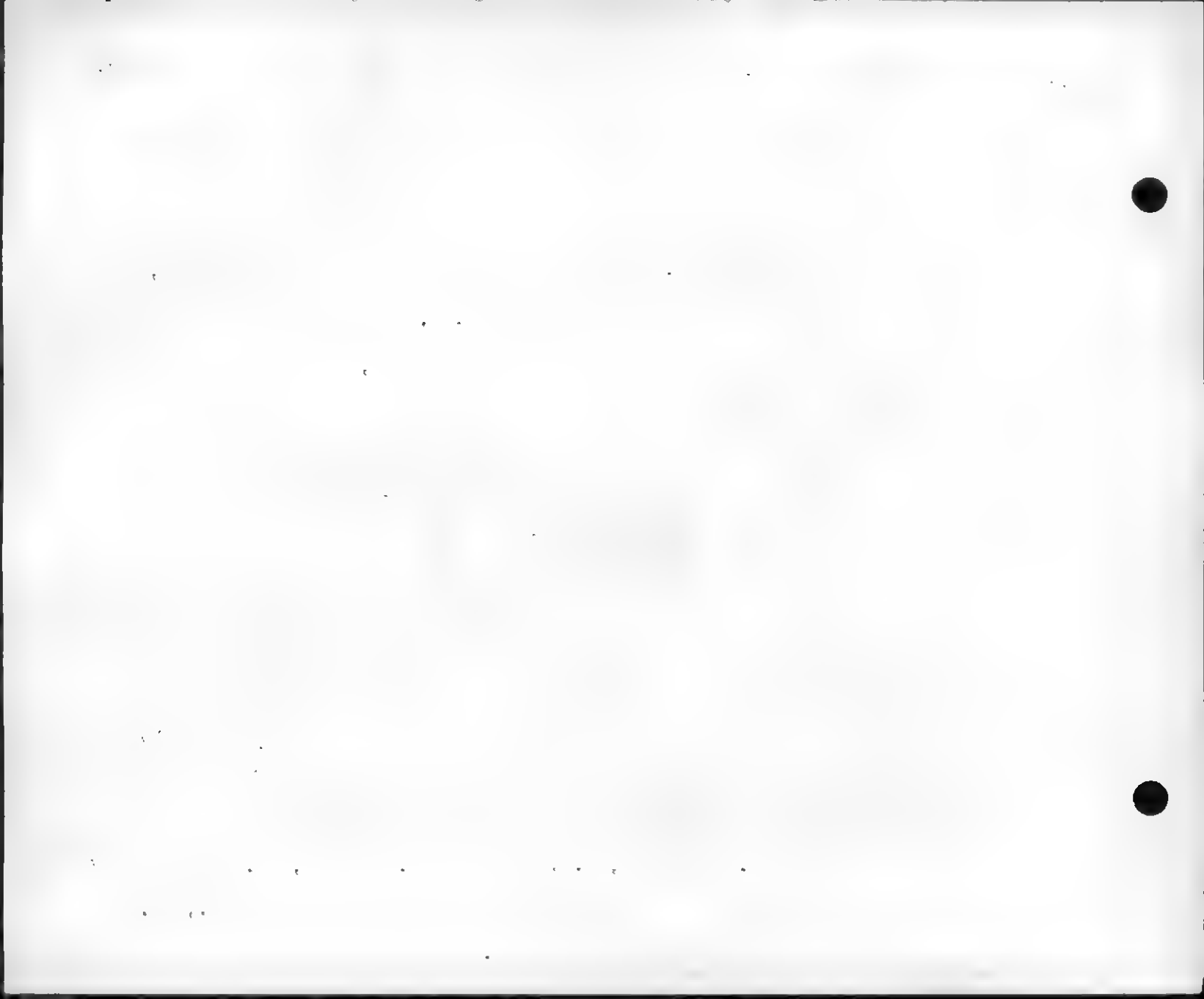
13461

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the other pages. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b STATE Maryland c COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c LENGTH OF STAY IN 1b Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1437 Galena Road		e STREET ADDRESS 1437 Galena Road	
3 NAME OF DECEASED (Type or print) First Middle Last LILLIAN V. GOUKER		4 DATE OF DEATH Month Day Year October 11, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 9, 1901
9 AGE (In years last b. rthday) yrs 66		10 UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Patrick O'Connor		14 MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO ?	
17 INFORMANT George Gouker		Address Same	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarct DUE TO ACVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theodore C. Patterson M.D.		22. DATE SIGNED 10/13/67	
EXAMINER'S NAME (Type) Theodore C. Patterson, M.D. 105 Main St. Dundalk, Md. 21222		23a LOCATION (City or town) (County) (State) Baltimore Co., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 10/14/67	23c NAME OF CEMETERY OR CREMATORY Gardens of Faith	
24 FUNERAL DIRECTOR Brazdzinski Funeral Home 1407 Eastern Ave.		25a REC'D BY REGISTRAR DATE OCT 17 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23c per telephone conversation with hospital
CERTIFICATE OF DEATH 10527

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore 21213		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 3727 Elmley Ave.		
3 NAME OF DECEASED (Type or print) First Middle Last Kathryn Graleski			4 DATE OF DEATH Month Day Year October 25, 19 67		
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 25, 1967		9 AGE (In years last birthday) Yrs 7 Min 44
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Ronald Adam Graleski			14 MOTHER'S MAIDEN NAME Joanne Alice Bowers		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple congenital anomalies DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/25/ , 19 67 , to 10/25/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/25/ , 19 67 and that death occurred at 5:25PM , from causes and on the date stated above.					
22a SIGNATURE <i>Laurence Misanik</i>			22b. DATE SIGNED		22c. ADDRESS 7620 York Rd., Towson, Md., 21204
22c PHYSICIAN'S NAME (Type) LAURENCE MISANIK M.D.		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY U. of M. Anatomy Board		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 13 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

<div>1</div> <div>62</div> <div>13467</div>									
<div>1</div> <div>62</div> <div>13467</div>									
1. PLACE OF DEATH a. COUNTY BALTIMORE					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTIMORE County GENERAL					d. STREET ADDRESS 2832 MARNAT RD.				
3. NAME OF (Type or print) ABRAHAM					4. DATE OF DEATH Oct 29 1967				
5. SEX MALE					6. COLOR OR RACE WHITE				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH 3/15/1895				
9. AGE (In years last birthday) 69 yrs.					10. IF UNDER 1 YEAR Months 7 Days 14				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber					10b. KIND OF BUSINESS OR INDUSTRY SHOP				
11. BIRTHPLACE (County & State, or foreign country) Russia					12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME MORRIS GREENBERG					14. MOTHER'S MAIDEN NAME MIRIAM				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. XXXXXX XXXX XXXX				
17. INFORMANT MRS. ANNA GREENBERG, 2822 MARNAT RD. #21208					Address 2822 MARNAT RD. #21208				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Lung 10-11 DUE TO Conditions, if any, which gave rise to immediate cause (b) 10-11 (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 9-28-67 to 10-29-67 that (I) (the) last saw the deceased alive on 10-29-67 , and that death occurred at 11:20 a.m. from the causes and on the date stated above									
22a. SIGNATURE Rolando A. Padambz									
22b. DATE SIGNED 10-27-67									
22c. PHYSICIAN'S NAME (Type) DR. S. N. TOMPAKOV									
22d. ADDRESS 3600 Park Heights Ave									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 10-31-67									
23c. NAME OF CEMETERY OR CREMATORY MOSES MONTIFLORE WOODHOP									
23d. LOCATION (City, town or county) (State) HEBREW BALTIMORE, MARYLAND									
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC., XXXX6010 REISTEPSTOWN RD									
25a. REC'D BY REGISTRAR DATE NOV 6 1967									
25b. REGISTRAR'S SIGNATURE J Charles Judge									



13463

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G395 11/21/67 kk

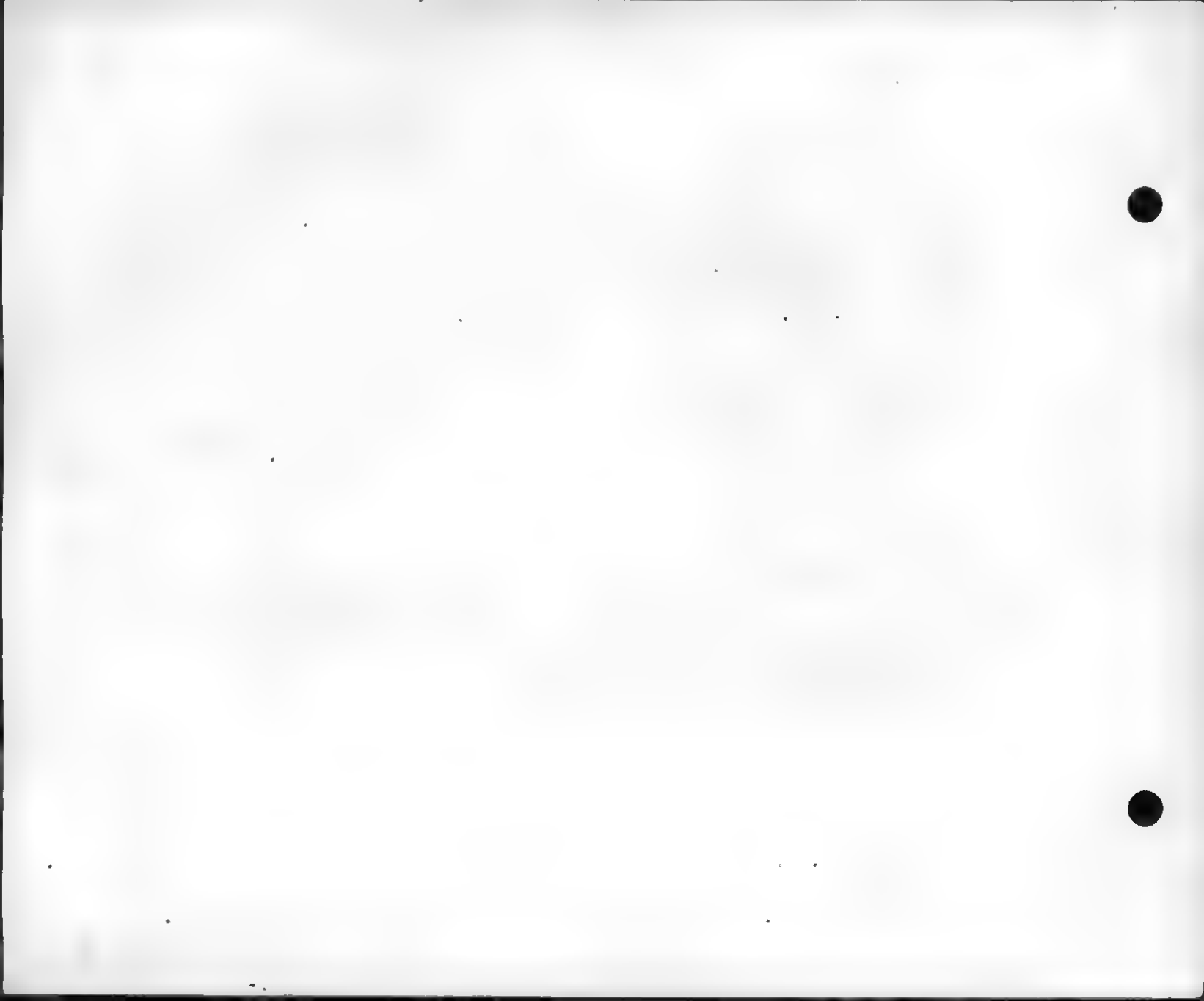
CERTIFICATE OF DEATH

13468

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21229	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS 4402 Dunland Rd. Apt. E	
3. NAME OF DECEASED (Type or print) Margaret E. Griffith		4. DATE OF DEATH Month October , Day 21 , Year 1967	
5. SEX Female	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1888
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Squires		14. MOTHER'S MAIDEN NAME Catherine Stumph	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Richard Carter Sr. 1190 W Belvedere		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1967 IMMEDIATE CAUSE (a) Sarcoma of right femur DUE TO (b) DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October, 1966 to Oct 20, 1967 that (I) (we) last saw the deceased alive on Oct. 19, 1967 , and that death occurred at 5 P.M. from causes and on the date stated above.			
22a. SIGNATURE D. C. MacLaughlin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin		22d. ADDRESS 303 N Rolling Rd Catonsville 28 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 23, 1967	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville Md.	
24. FUNERAL DIRECTOR Witzke & Sons 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR OCT 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

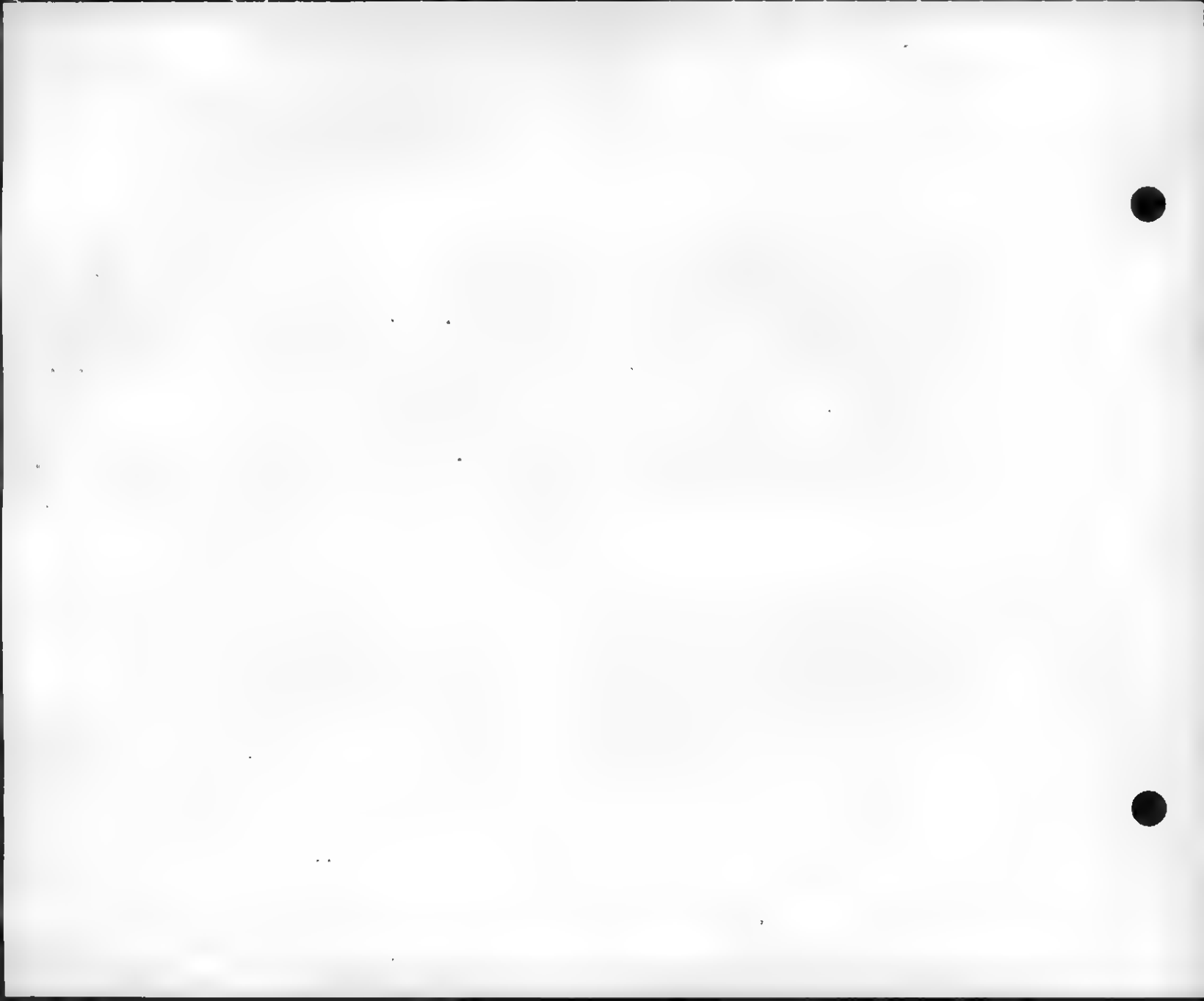
13464

13469

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN IS <u>51 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 Hanover Road</u>				d. STREET ADDRESS <u>111 Hanover Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARMON</u> Middle <u>OLIN</u> Last <u>GRIMES</u>				4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Gas & Elec.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis A. Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Marian Marsh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-65-3312</u>		17. INFORMANT <u>Mrs. Lydia Grimes</u> Address <u>111 Hanover Rd. Reisterstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>18 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>none</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-1-41</u> , 19 to <u>10-17-67</u> , 19, that (I) (we) last saw the deceased alive on <u>Oct. 13</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>D. D. Caples</u>				22b. DATE SIGNED <u>10-19-67</u>		22c. PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>H. J. Schhardt</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13470

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3712 BUCKINGHAM RD.</u>	
3 NAME OF DECEASED (Type or print) <u>GEORGE A GROSS</u> First Middle Last 5 SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>2/25/03</u> 9 AGE (n years last birthday) <u>64</u> yrs. 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u> 10b KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		4. DATE OF DEATH <u>Oct. 25</u> 19 <u>67</u> Month Day Year 11 BIRTHPLACE (County & State or foreign country) <u>BALTO. MD</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Christian Gross</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO <u>312-05-4054</u> 17 INFORMANT <u>Estelle E. Gross - SAME</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>✓ Acute Myocardial Infarction</u> <u>7201</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED _____ M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) _____ 22d. ADDRESS _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10-28-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial Gardens - BALTO. MD</u> 23d. LOCATION (City or Town) _____ (County) _____ (State) _____		24. FUNERAL DIRECTOR <u>Ellsworth Armbrust - 4601 Liberty Heights Ave</u> 25a. REC'D BY REGISTRAR <u>DA</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



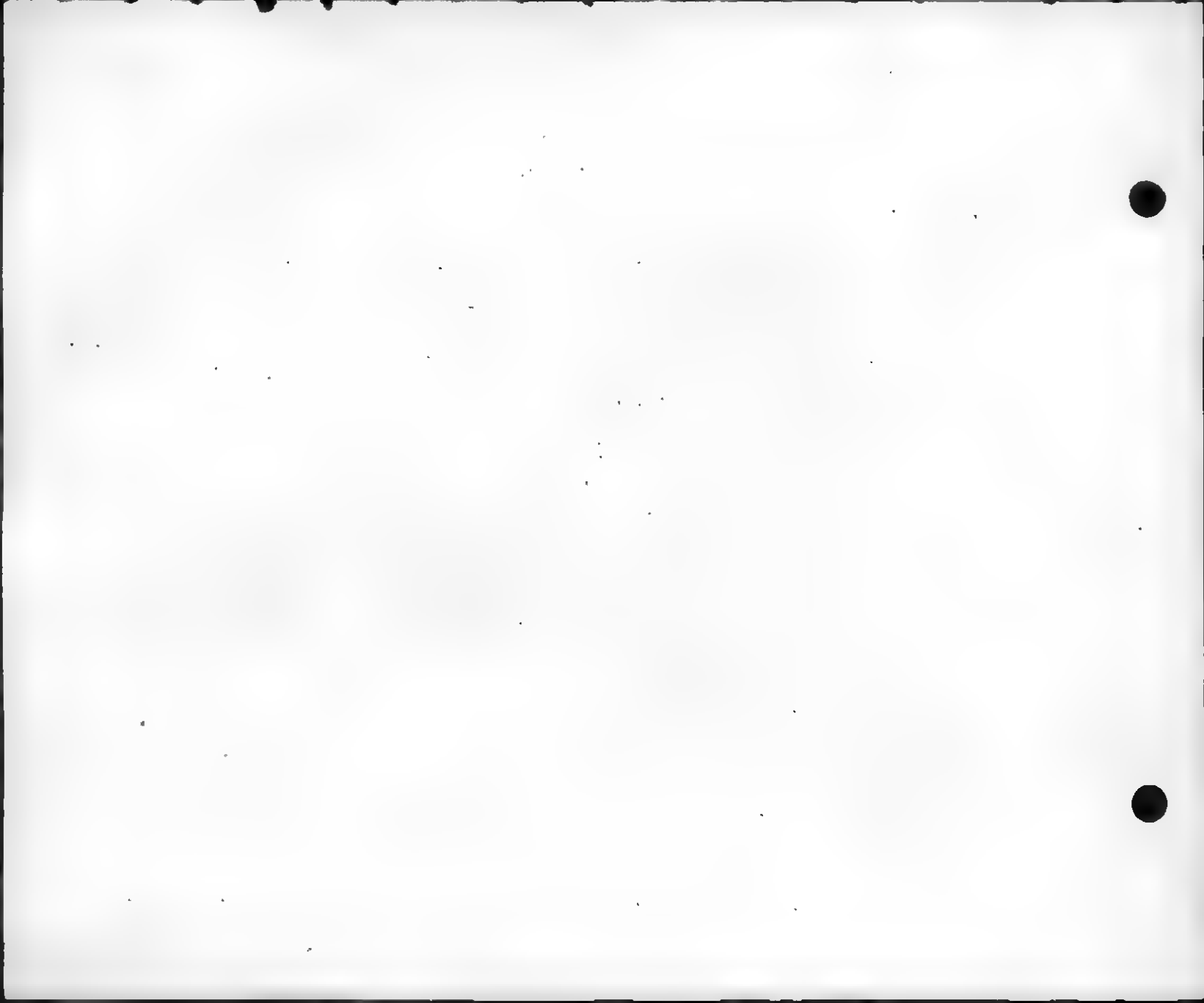
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VR A15
20M 1/6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN ID <i>46 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore MD.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Baltimore Medical Center</i>				d. STREET ADDRESS <i>1916 Park Place</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Alice</i> Last <i>Haddaway</i>		4. DATE OF DEATH Month <i>October</i> Day <i>23</i> Year <i>1967</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>Cauc.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-04-87</i>		9. AGE (In Years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Frederick City, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Scott Reightler</i>		14. MOTHER'S MAIDEN NAME <i>Martin</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <i>213-03-4280</i>		17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic well differentiated</i> DUE TO <i>adeno Carcinoma - Primary Schirrhous</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Selective indicating Primary ovarian</i> (c) <i>Carcinoma</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Intestinal obstruction 20 to 40</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>9/07</i> , 19 <i>67</i> to <i>10/23</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10/23</i> , 19 <i>67</i> , and that death occurred at <i>7:55</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Acquinque</i>		22b. DATE SIGNED <i>10/23/67</i>	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
23b. DATE THEREOF <i>10/26/1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LOCKRAINE PARK</i>		23d. LOCATION (City, town or county) (State) <i>BALTIMORE MD.</i>		24. FUNERAL DIRECTOR ADDRESS <i>WITZKE & SONS 4101 EDMONDSON AVE.</i>	
25a. REC'D BY REGISTRAR <i>Oct 25 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>					



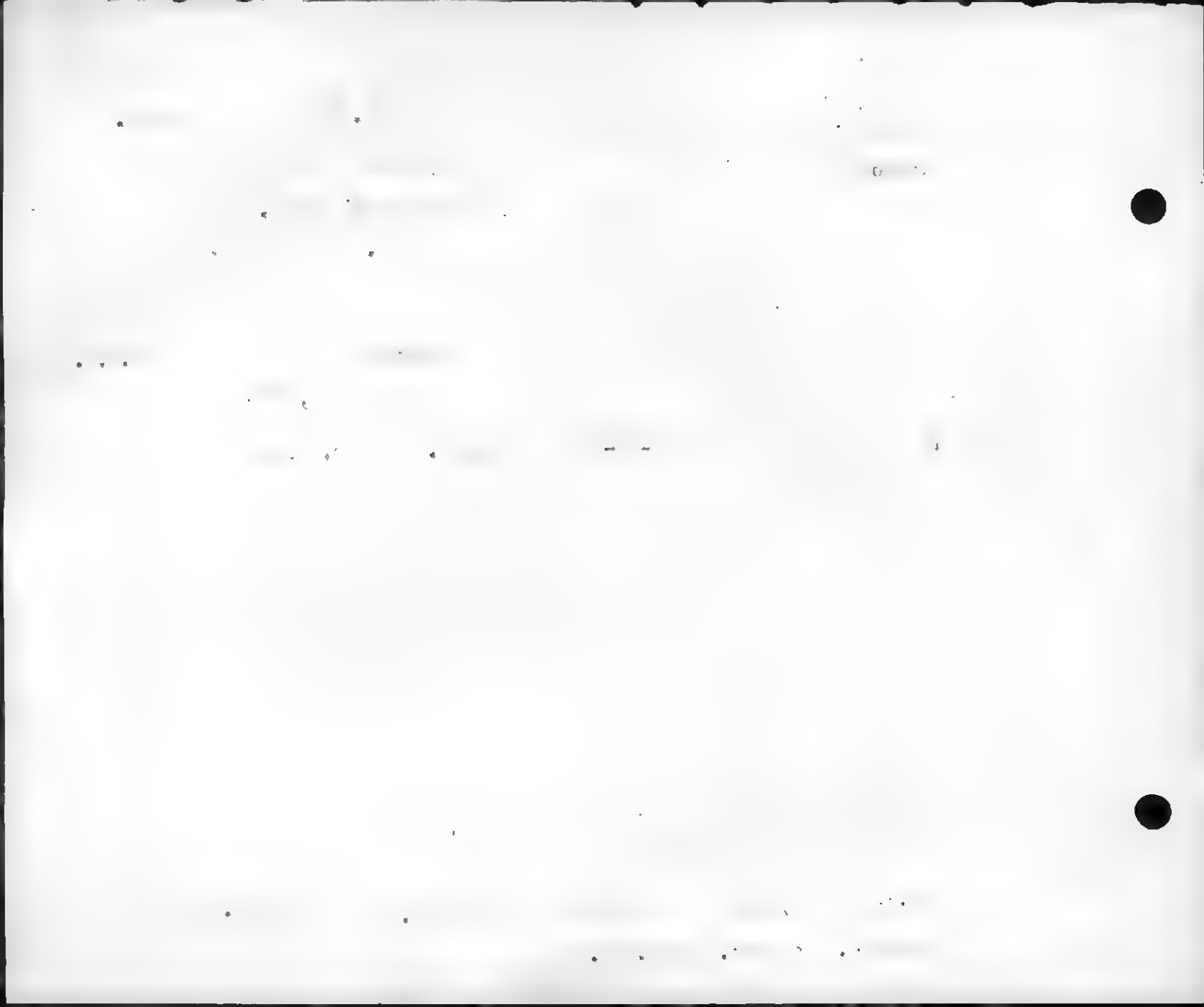
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13472
13267
12
1
11

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> d. STREET ADDRESS <u>3001 Pulaski Hgway.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>ALBERT</u> Last <u>Hale Sr.</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1967</u>		9. AGE (in years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hale Trailer Man</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES Hale</u>		14. MOTHER'S MAIDEN NAME <u>JACKSON, Edna</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-05-4036</u>		17. INFORMANT <u>Harry A. Hale Jr. same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u> DUE TO (b) <u>CA of esophagus</u> DUE TO (c) <u>esophageal rupture</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-15</u> , 19 <u>67</u> , to <u>10-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-7</u> , 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Rahim Bassiri</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>DR. RAHIM BASSIRI</u>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY. <u>Gardens of Faith Cem.</u>			
23d. LOCATION (City, town or county) <u>Balto. Md</u>		(State)					
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

13468
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

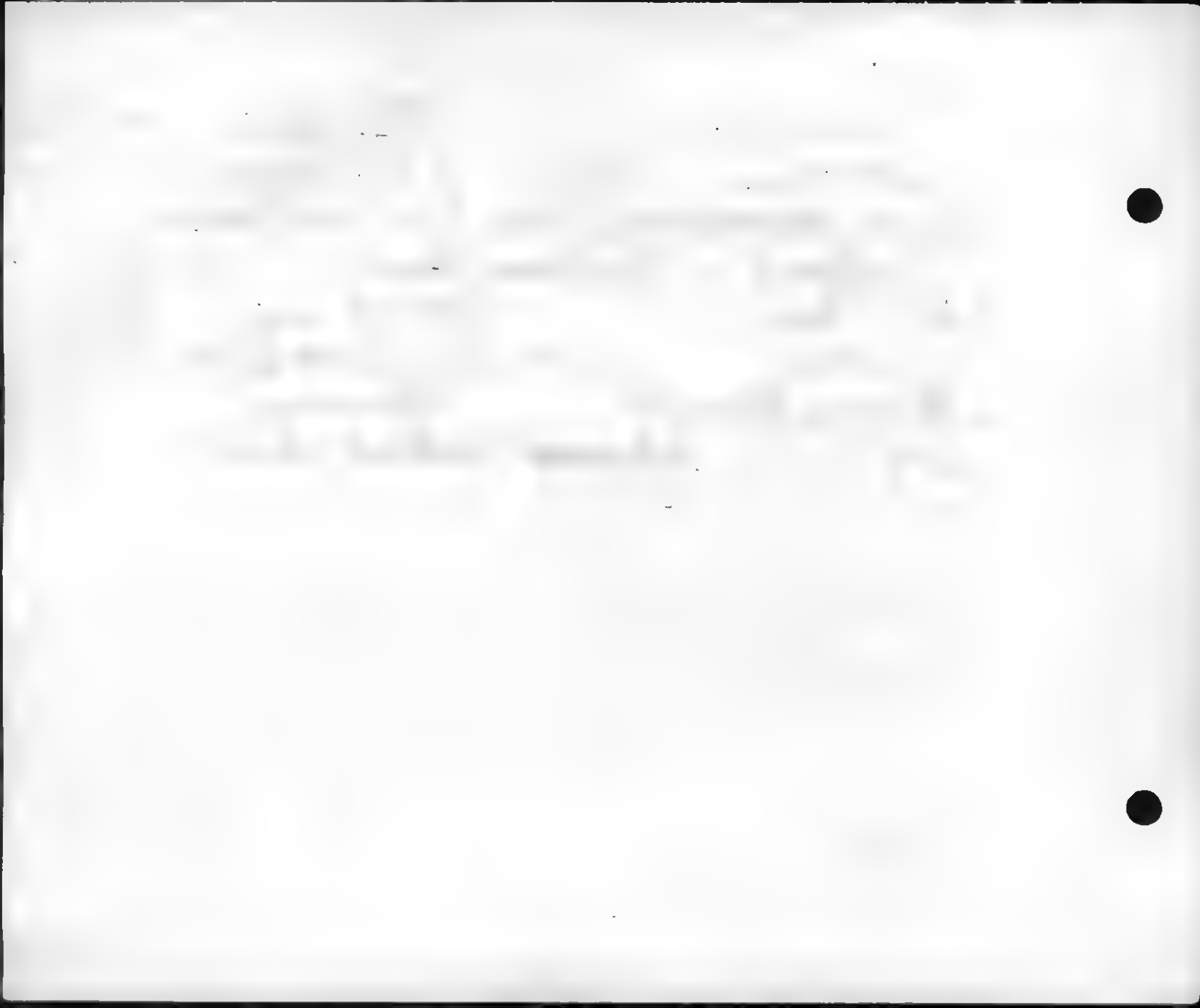
CERTIFICATE OF DEATH

13473

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN b 2 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 39 Hanover Street	
3. NAME OF DECEASED (Type or print) First William Middle Lionel Last HAMPTON		4. DATE OF DEATH Month 10 Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-57
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 10 yrs.
11. BIRTHPLACE (County & State, or foreign country) Flavre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tilghman Hill		14. MOTHER'S MAIDEN NAME Eleanor Bond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	17. INFORMANT Rosewood Records, Owings Mills, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Orthostatic bronchial pneumonia DUE TO (b) Astrocytoma Grade I-II DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 7 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/8 , 19 67 , to 10/13 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/13 , 19 67 , and that death occurred at 3:05a , from causes and on the date stated above			
22a. SIGNATURE Richard A. Jones		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 10-13-67
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22d. ADDRESS Rosewood State Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY St. James A.M.E. Cemetery	23d. LOCATION (City or Town) (County) (State) Gravelly Hill, Harford Co. Md.
24. FUNERAL DIRECTOR Elmer E. Bullock		25a. REC'D BY REGISTRAR Flavre de Grace	25b. REGISTRAR'S SIGNATURE Charles Judge



VR A15 (4
25M 1/67



CERTIFICATE OF DEATH

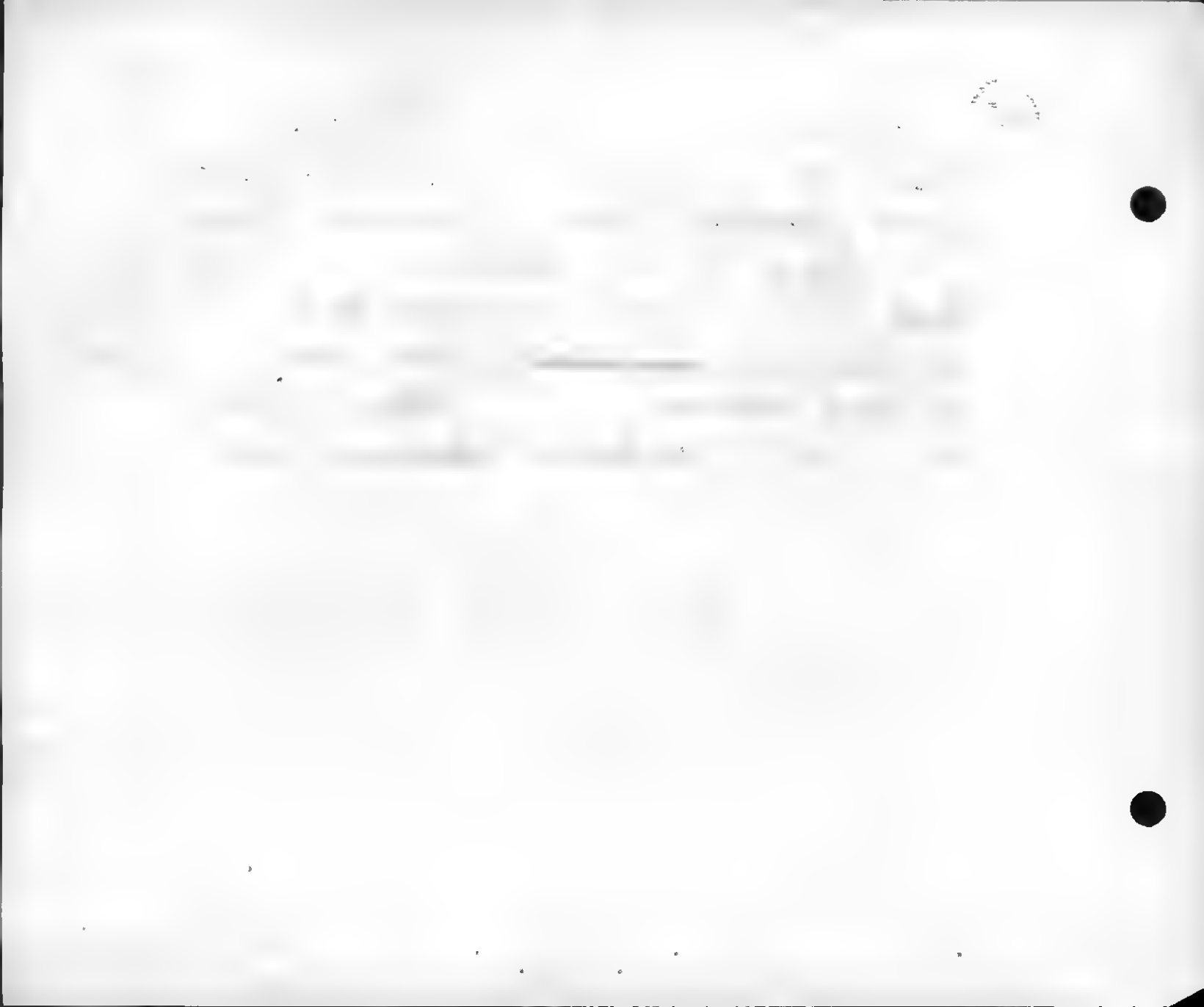
13475

12470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DATA</u> c. LENGTH OF STAY IN b <u>20 DAYS</u>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>1 E. University Pkwy</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Greater Balto Med. Center</u>		d. STREET ADDRESS <u>Balto. MD. Zone 18</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Marie</u> First Middle Last <u>L. Hardwell</u>		4. DATE OF DEATH <u>10-2-1967</u> Month Day Year	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cau.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-1896</u> 9 AGE (In years last birthday) <u>71</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>BALTO. MD.</u>		12 CITIZENSHIP OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Millard Leonard</u>		14. MOTHER'S MAIDEN NAME <u>SOUTHCOMB Mary Leonard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>057 100 5870</u>	
17 INFORMANT <u>Admission Sheet</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170 x</u> DUE TO <u>CANCER OF BREAST II</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>METASTASIS TO THE LUNGS</u> DUE TO (b) <u>170 x</u> DUE TO (c) <u>METASTASIS TO THE LUNGS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Nat. Wh. at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-13</u> , 19 <u>67</u> , to <u>10-2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-2</u> , 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Jorge M. de Leon, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Jorge M. de Leon, M.D.</u>		22b. DATE SIGNED <u>10-2-67</u> 22d. ADDRESS <u>Greater Balto. Medical Center</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>10/4/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24 FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25a REC'D BY REGISTRAR <u>Oct 3 1967</u> 25b REGISTRAR'S SIGNATURE <u>Jorge M. de Leon</u>	

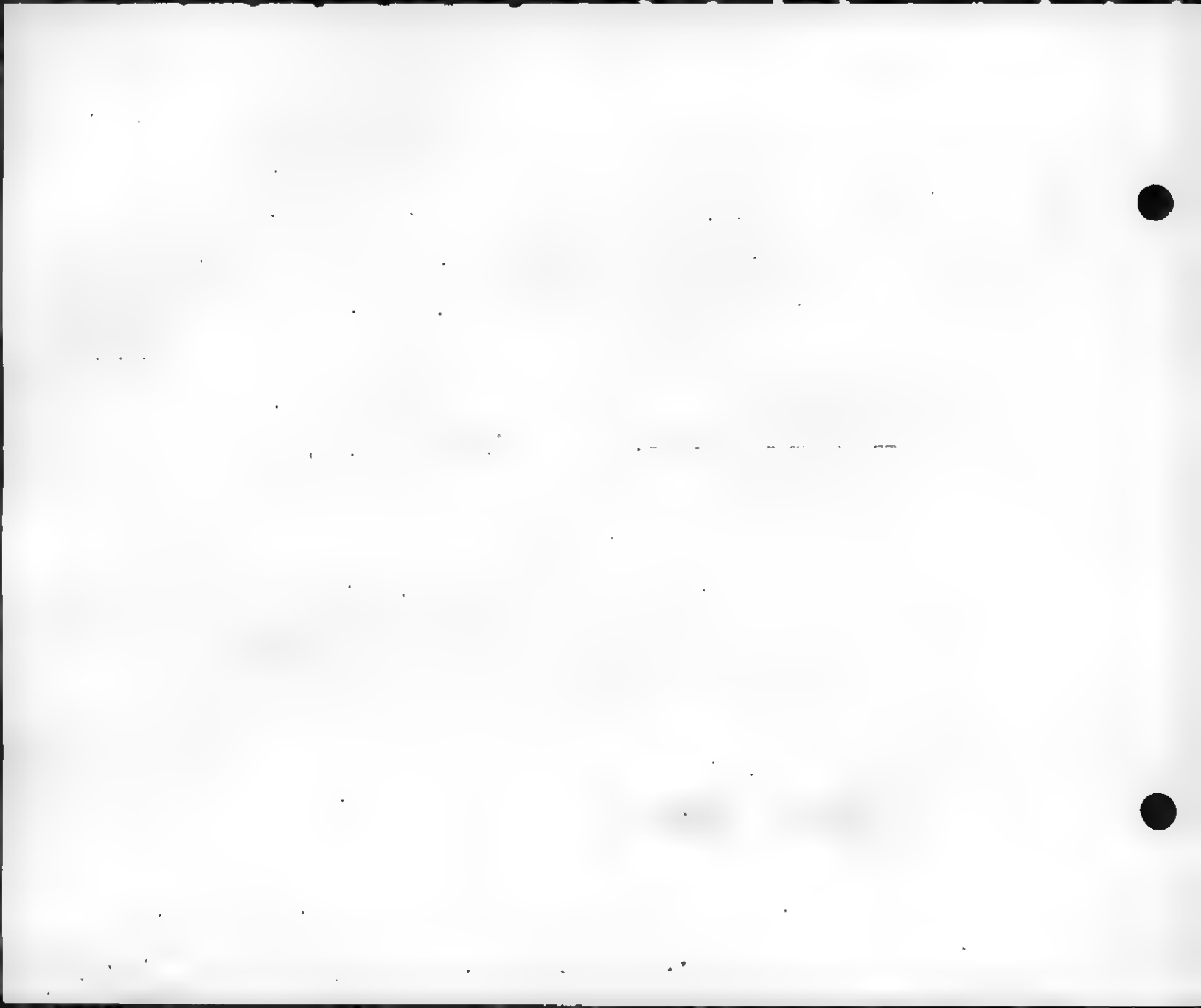


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13476 CERTIFICATE OF DEATH 13476									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Towson</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> <u>21204</u> d. STREET ADDRESS <u>615 Chestnut Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>LEE</u> Last <u>HARVEY</u>					4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>19 67</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 24, 1884</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse R/N</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Edward Harvey</u>					14. MOTHER'S MAIDEN NAME <u>Ann Virginia Dwyer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-03-5015</u>		17. INFORMANT Address <u>Pickersgill Home, same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrolyte imbalance</u> DUE TO (b) <u>Intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Volvulus of cecum with adhesions</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 11, 1967</u> to <u>Oct. 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 12, 1967</u> , and that death occurred at <u>2:45M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John E. Adams</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>Oct. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Patuxent Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sunshine, Maryland</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</u>						25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

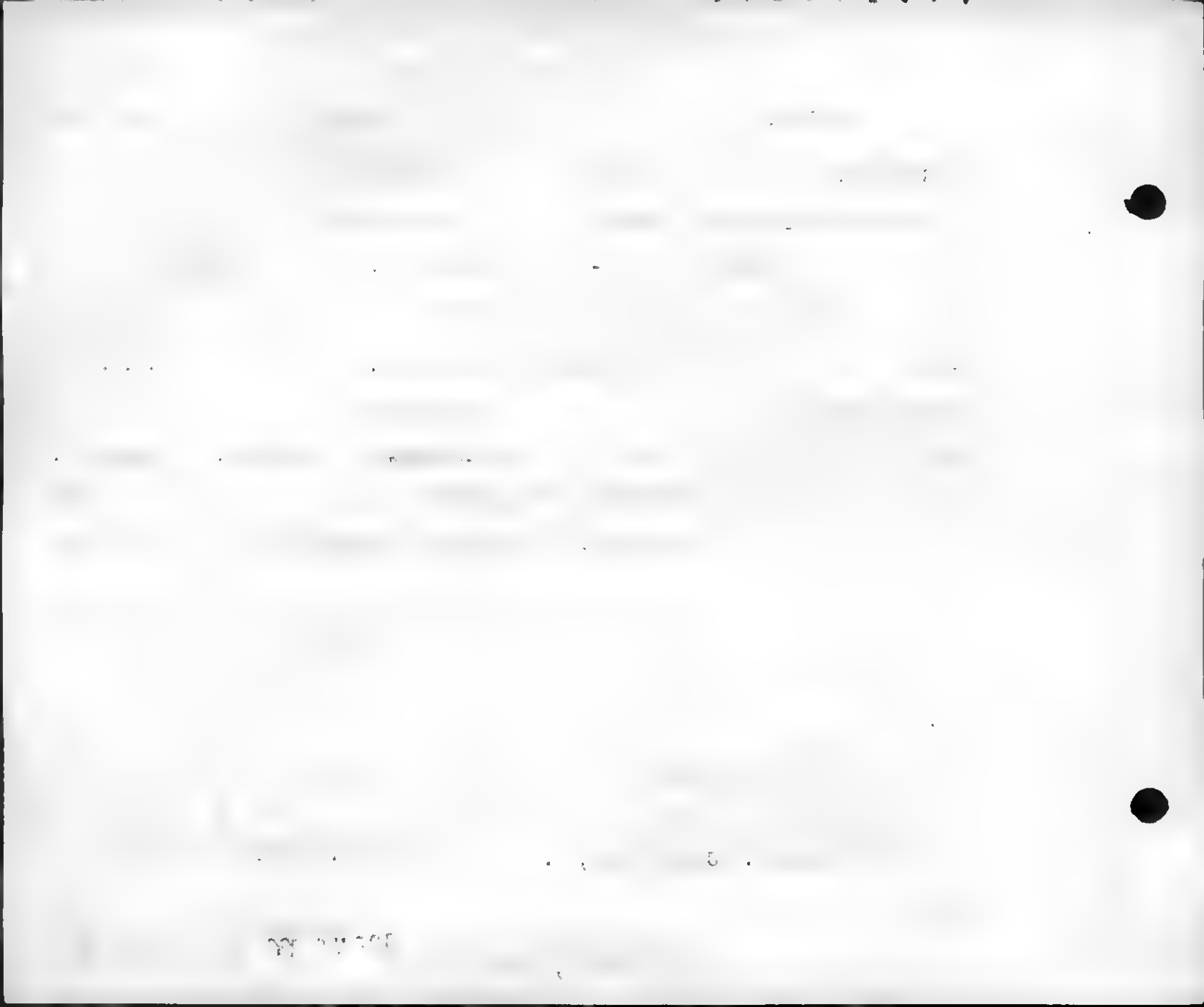
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13472

CERTIFICATE OF DEATH

13477

1. PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ANNE ARUNDEL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d STREET ADDRESS 311 WEST STREET	
3 NAME OF DECEASED (Type or print) First Middle Last GEORGE -- HASTE, JR.		4 DATE OF DEATH Month Day Year OCTOBER 18 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/8/17
9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR Months Days 18 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10b. KIND OF BUSINESS OR INDUSTRY NAVAL ACADEMY	
11 BIRTHPLACE (County & State or foreign country) ANNAPOLIS, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GEORGE HASTE		14 MOTHER'S MAIDEN NAME ANNIE CREEK	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 214 05 17 11	
17 INFORMANT Address CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1558 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CARCINOMA OF LARGE BOWEL WITH METASTASIS TO LIVER DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that he (this hospital) attended the deceased from 10/6/67 , 19 to 10/18/67 , that he (we) last saw the deceased alive on 10/18/67 , 19, and that death occurred at 4:15PM from causes and on the date stated above			
22a SIGNATURE <i>George C. M. Elfatrick M.D.</i> MD		22b. DATE SIGNED 10/19/67	
22c PHYSICIAN'S NAME (Type) GEORGE C. M. ELFATRICK, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 10-23-67	23c NAME OF CEMETERY OR CREMATORY Brewer Hill	23d LOCATION (City or Town) (County) (State) Annnapolis MD
24 FUNERAL DIRECTOR <i>William Reese Jr.</i>		25a BY REGISTERED REESE FUNERAL HOME ANNAPOLIS, MARYLAND	



1

4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

23473

CERTIFICATE OF DEATH

13478

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Pikesville c. LENGTH OF STAY in 1b 12 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Foxleigh Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5726 Uffington Rd. 21209 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie First O Middle Hearn Last		4. DATE OF DEATH Oct. 30 Month 19 67 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13 1877
9. AGE (in years last birthday) 90 vs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Orem		14. MOTHER'S MAIDEN NAME Virginia Frazier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 218-54-2671 JJ	
17. INFORMANT Miss Mildred Hearn Balto. Md. Address 5726 Uffington Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.V. & other diseases		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 weeks 9/19/67	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in home and struck hip from on fireplace screen	
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 9/19 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home		20f. (City or town) (County) (State) BALTIMORE MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 1/16, 1967 to 10/24, 1967 , that (I) (we) last saw the deceased alive on 10/24 1967 , and that death occurred at 7:34 M. from causes and on the date stated above.			
22a. SIGNATURE Jeanette R. Heghinian 22c. PHYSICIAN'S NAME (Type) Dr. Jeanette R. Heghinian		22b. DATE SIGNED 10/31/67 22d. ADDRESS 2212 South Road Balto. Md.	
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE THEREOF 11/2/67	
23c. NAME OF CEMETERY OR CREMATORY Cambridge		23d. LOCATION (City or Town) (County) (State) Cambridge Md.	
24. FUNERAL DIRECTOR Erving Myers Address 8728 Liberty Rd Randallstown Md		25a. REG'D BY REGISTRAR NOV 2 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

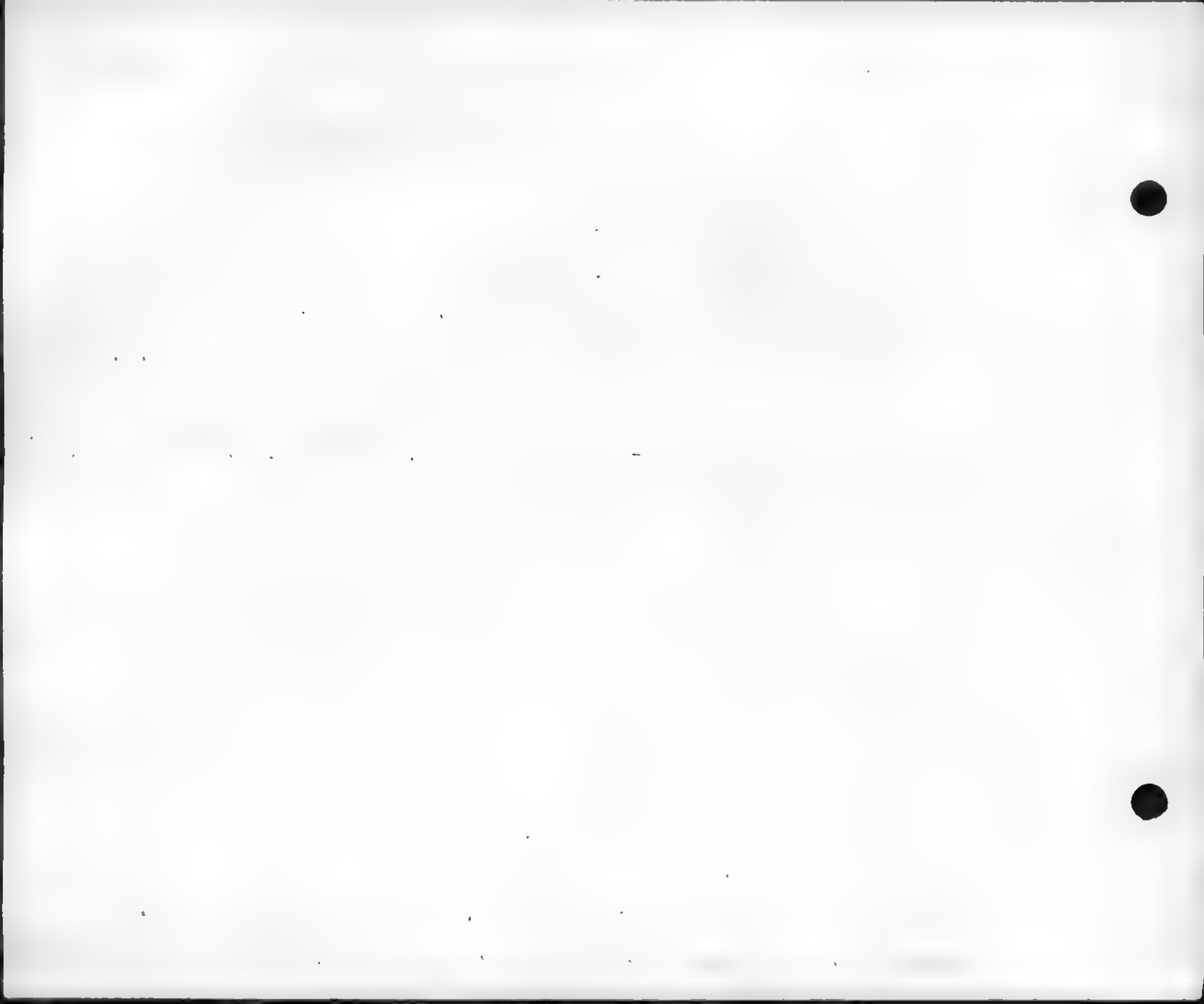
134779

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		e. STREET ADDRESS <u>3014 Linwood Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Margaret M. Heill</u>		4 DATE OF DEATH <u>10/28/67</u> 19 <u>67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 7, 1905</u> 62 yrs
9 AGE (In years most birthday) <u>62</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life (retired)) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>220-78-2694</u>	
17 INFORMANT <u>Henry P. Heill Jr.</u> Address <u>Timonium, Md. 31 Vans Ave.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year <u>19</u> hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) <u>10/28/67</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 2 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13480

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn c. LENGTH OF STAY IN b Woodlawn d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2422 Rolling Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 2422 Rolling Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rowena E. Hemmings		4. DATE OF DEATH Month October Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1885
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Tazewell Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Yost		14. MOTHER'S MARDEN NAME Harriet Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 22026	
17. INFORMANT Mrs. Frieda Beinschla		Address Balt. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1. IN IMMEDIATE CAUSE (a) Emphysema DUE TO (b) Compensated of chronic with metastasis DUE TO (c) Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 8, 1967 , to October 13, 1967 , that (I) (we) last saw the deceased alive on October 13, 1967 , and that death occurred at 2:28 P.M. from causes and on the date stated above.			
22a. SIGNATURE Edwin L. Pierpont		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.		22d. ADDRESS 8204 LIBERTY RD - Balt. 21207 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/15/67	23c. NAME OF CEMETERY OR CREMATORY Hankins Cemetery	23d. LOCATION (City or town) (County) (State) Richlands Tazewell Va.
24. FUNERAL DIRECTOR Living Byrne		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 16 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

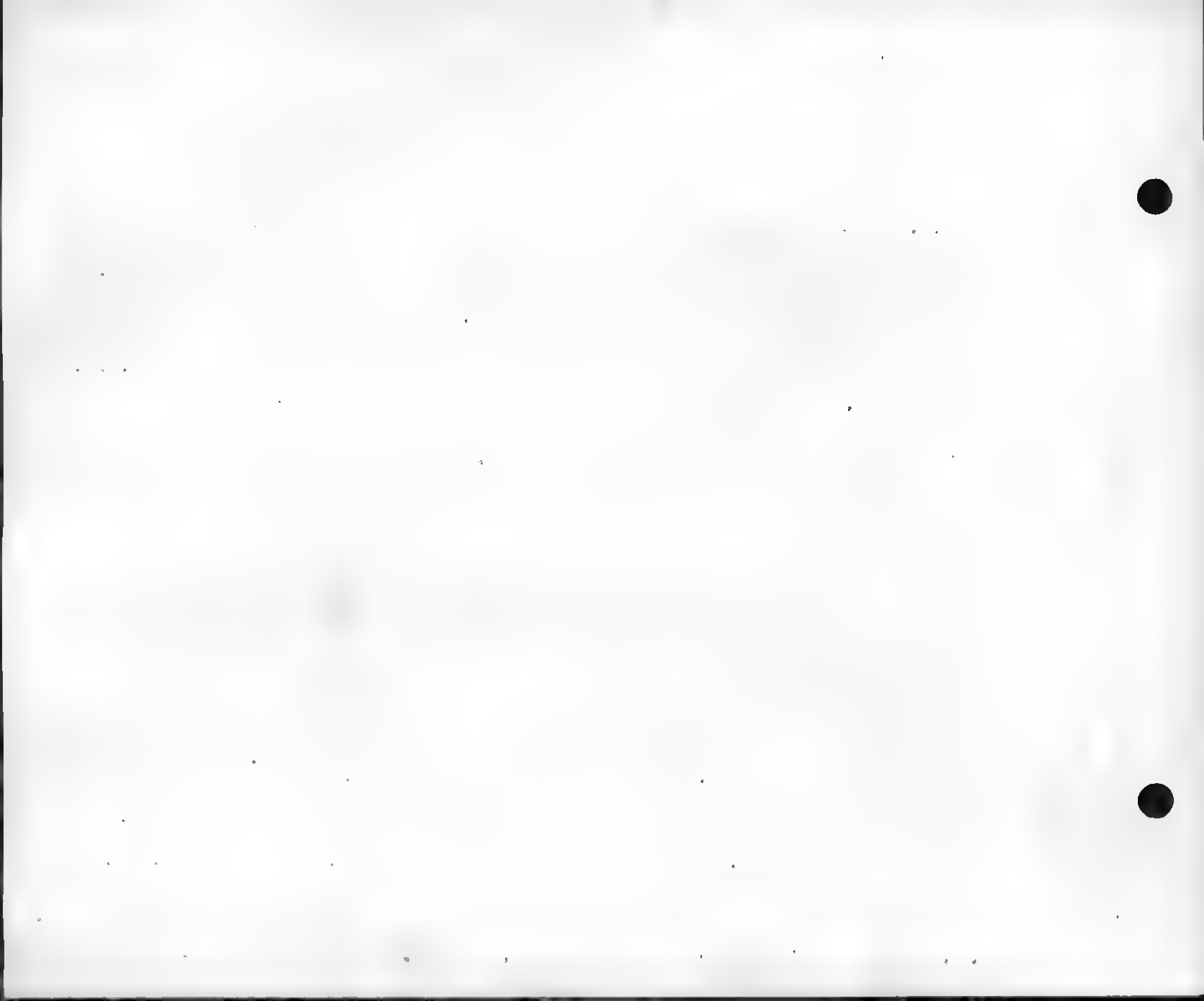
13476

CERTIFICATE OF DEATH

13-181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 21218</u> d. STREET ADDRESS <u>1731 Chilton St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Franklin W Henderson</u>			4. DATE OF DEATH Month Day Year <u>October 20, 1967</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1885</u>	9. AGE (In years last birthday) <u>81</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing & Heating</u>		11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>George W. Henderson</u>				
14. MOTHER'S MAIDEN NAME <u>Mary V. Arthur</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO <u>215-03-6184</u>		17. INFORMANT Address <u>Mrs. Eva I. Henderson Above</u>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal Failure and Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>Arteriosclerotic Nephrosclerosis, Basilar Artery Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 17</u> , 19 <u>67</u> , to <u>Oct. 20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Oct. 20</u> , 19 <u>67</u> , and that death occurred at <u>11:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Beatriz P. Dizon</u> M.D.			22b. DATE SIGNED <u>10-20-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Beatriz P. Dizon</u>		
22d. ADDRESS <u>7620 York Rd., Towson-21204, Md.</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				
23b. DATE THEREOF <u>10-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Balto. Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd., Balto.</u>			25a. REC'D BY REGISTRAR <u>OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13477

13182

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Nursing Home</u>		d. STREET ADDRESS <u>2725 Maryland Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>E.</u> Last <u>Herbert</u>		4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1909</u>
9. AGE (in years last birthday) <u>57</u> yrs		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ormond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William B Herbert</u>		Address <u>Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cerebrovascular disease</u> DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>1964</u> , 19 <u>—</u> , to <u>Oct 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 27, 1967</u> , and that death occurred at <u>11 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John A Nesbitt Jr</u>		22b. DATE SIGNED <u>10-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John A Nesbitt Jr</u>		22d. ADDRESS <u>1004 Frederick Rd Balt. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 31 1967</u>	

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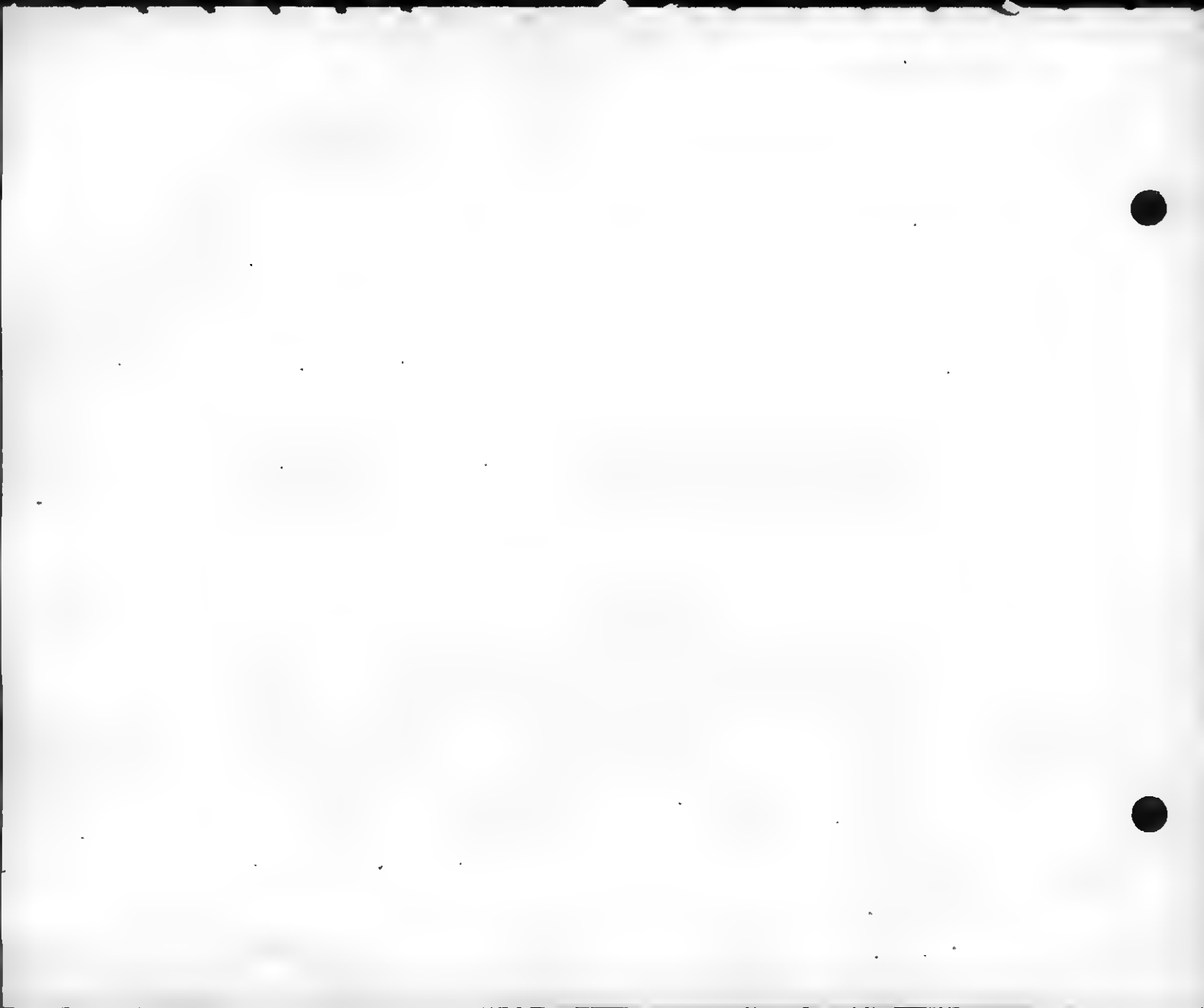


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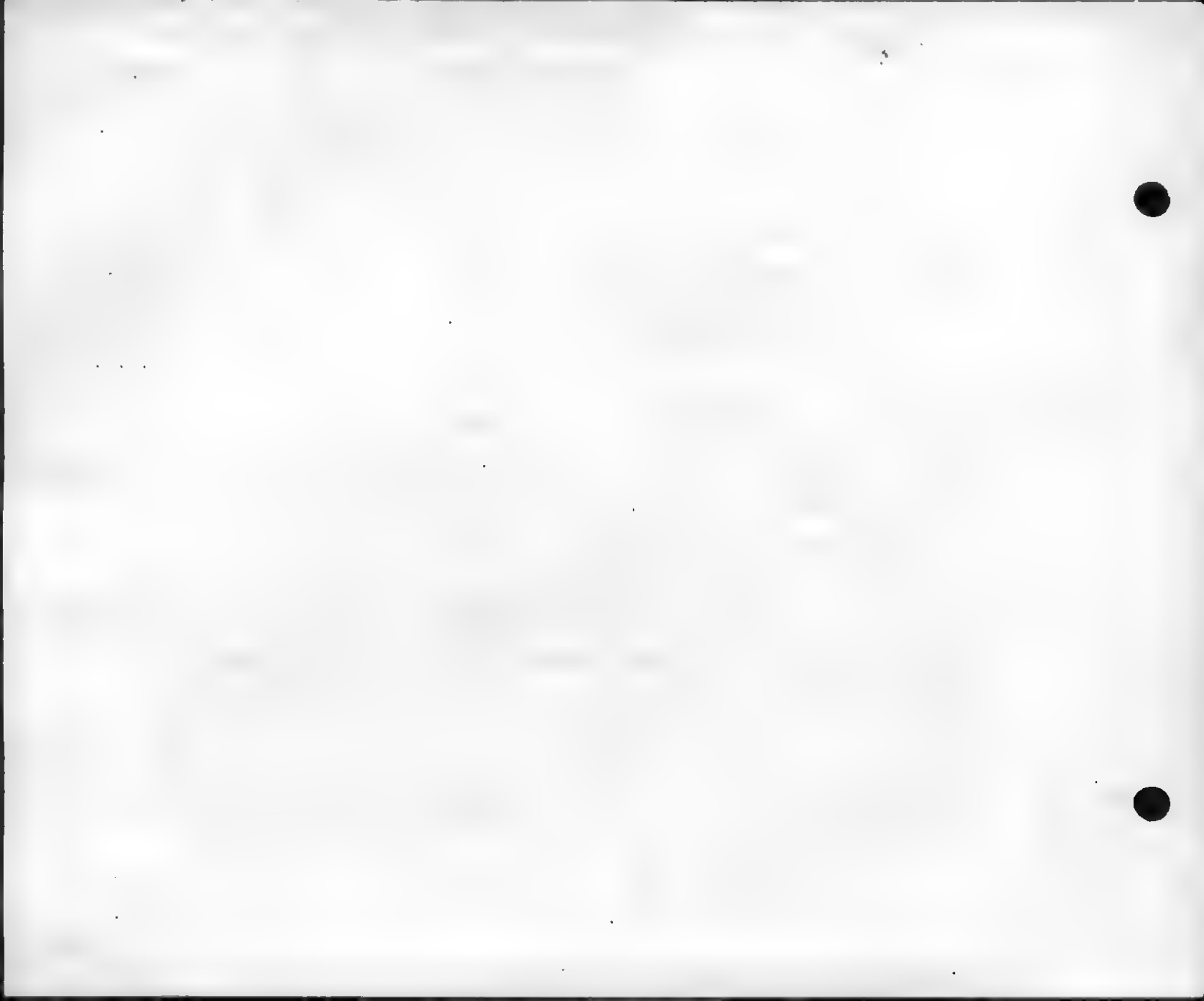
MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
13478													
13183													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JOHNSON</u>				c. LENGTH OF STAY IN 1b <u>18 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>						d. STREET ADDRESS <u>2607 HIRWOOD ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DORIS</u>			First <u>ELIZABETH</u> Middle <u>HESS</u> Last			4. DATE OF DEATH <u>OCTOBER 28, 1967</u>			Month <u>OCTOBER</u> Day <u>28</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 15, 1924</u>		9. AGE (in years last birthday) <u>43 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				
13. FATHER'S NAME <u>HARRY STETTES</u>						14. MOTHER'S MAIDEN NAME <u>MEISZ, Helen</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-14-5098</u>		17. INFORMANT <u>PATIENT'S CHART</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>diffuse and wide spread metastasis of cervical carcinoma</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 11, 1967</u> to <u>Oct 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 28, 1967</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Sh. Sh. Sh.</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Oct 28 67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Greater Baltimore Medical Center</u>						22d. ADDRESS <u>Greater Baltimore Medical Center</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>11-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>			23d. LOCATION (City, town or county) (State) <u>BALTO MD</u>					
24. FUNERAL DIRECTOR <u>CHAS F. EVANSTON</u>						ADDRESS <u>8802 Hartford Rd</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>OCT 31 1967</u>													



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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH					13484				
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium			c LENGTH OF STAY IN 1b Years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400 Chapel Wood Lane					d STREET ADDRESS 400 Chapel Wood Lane			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Florence Middle Darcy Last Higgins					4 DATE OF DEATH Month October Day 8 Year 1967				
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1891		9 AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Barnett					14. MOTHER'S MAIDEN NAME Katherine Buggy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO		17. INFORMANT Mrs. Florence Paul Address 400 Chapel Wood Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF BREAST 1100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 2 YRS	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 22, 1967 , to OCT 8, 1967 , that (I) (we) lost the deceased alive on Oct 8, 1967 , and that death occurred at 10A M. from causes and on the date stated above.									
22a. SIGNATURE William A. Pillsbury					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 10-9-67		
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury					22d. ADDRESS Timonium, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/67		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Texas Cemetery			23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.		
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson ADDRESS 1050 York Rd. 21204					25a REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE J. J. Jones		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

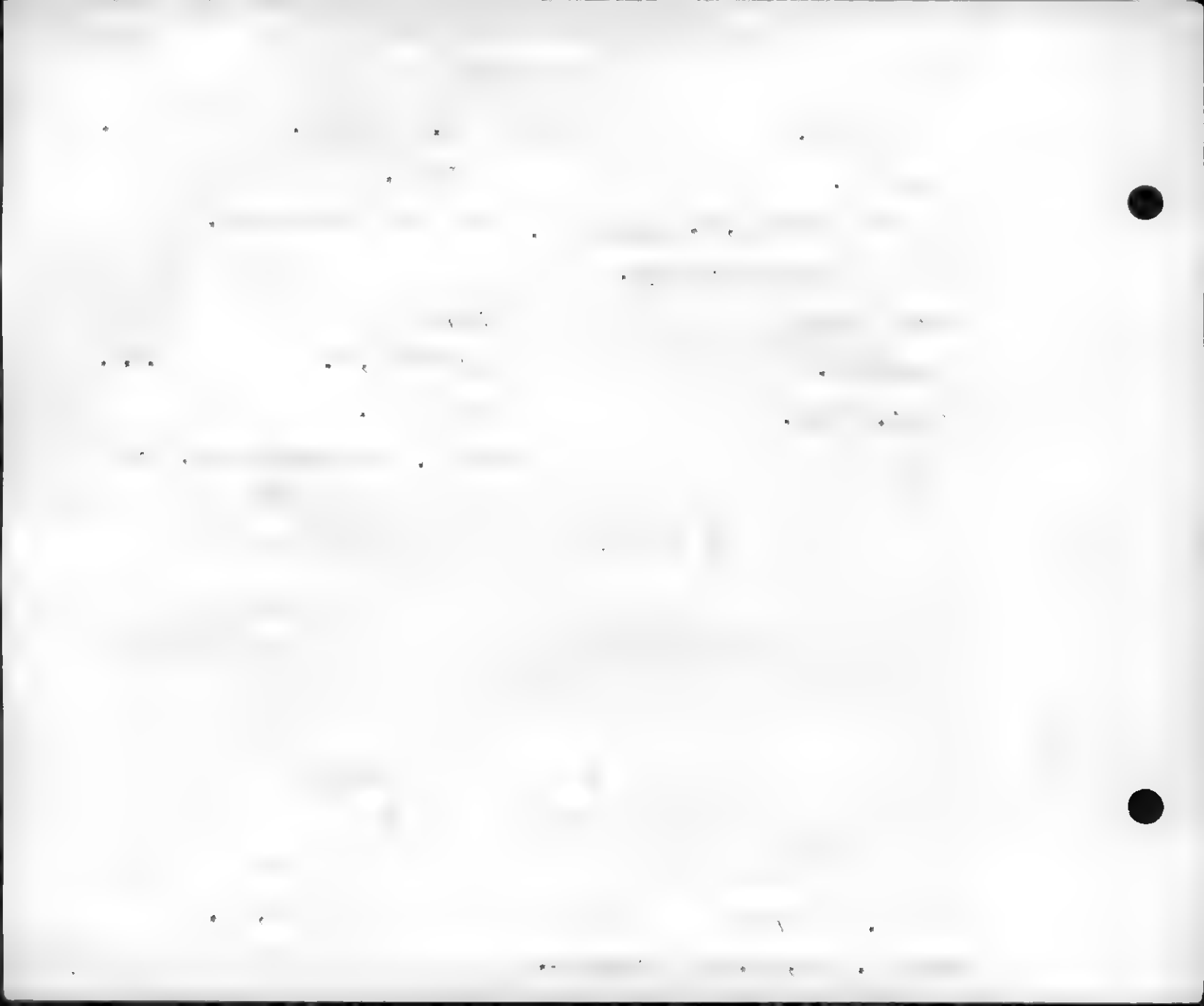
13485

CERTIFICATE OF DEATH

13480

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1. PLACE OF DEATH a. COUNTY Baltimore. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box #477 Kingsville, Md. Sunshine Ave.		d. STREET ADDRESS Box # 477 Kingsville, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Evelynn Mary Higgs.		4. DATE OF DEATH Month Day Year October 27 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1914
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Karl A. Gehler.		14. MOTHER'S MAIDEN NAME Mary Huber.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Kenneth E. Higgs Sunshine Ave. Box #477		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVA. BETWEEN ONSET AND DEATH 20 MDS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Ch. Cholelithiasis; Ch. Pancreatitis; Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/19 1966 to 10/27 1967 , that (I) (we) last saw the deceased alive on 10/27 1967 , and that death occurred 11:40 PM , from causes and on the date stated above			
22a. SIGNATURE CLIFFORD F. HUDSON M.D.		22b. DATE SIGNED 10/27/67	
22c. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON		22d. ADDRESS FERRIS, MD. 21051	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.		23b. DATE THEREOF 10/30/67	
23c. NAME OF CEMETERY OR CREMATORY Belair Memorial		23d. LOCATION (City or Town) (County) (State) Belair, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Rd.		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



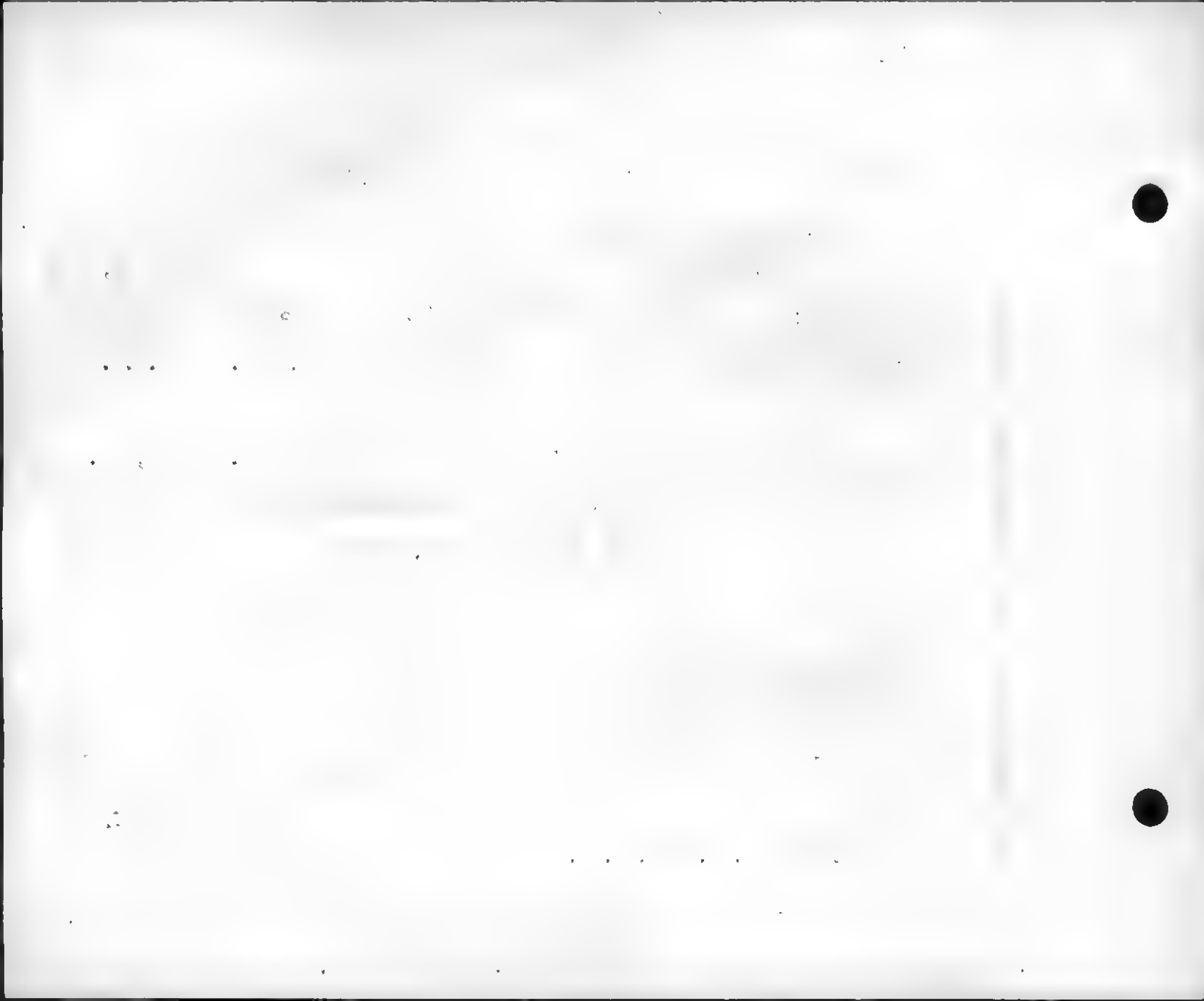
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIPPED TO: MORRIS FUNERAL HOME, CHELSEA, SOUTH CAROLINA

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 31 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1325 LUZERNE AVENUE	
3. NAME OF DECEASED (Type or print) First JAMES Middle HILLIAN Last HILLIAN		4. DATE OF DEATH Month OCTOBER Day 11 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/13
9. AGE (in years last birthday) 53		10. UNDER 1 YEAR Months 53 Days 53 Hours 53 Min 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
11. BIRTHPLACE (County & State, or foreign country) CHESTERFIELD, S. CAR.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUFES HILLIAN		14. MOTHER'S MAIDEN NAME SARAH MURIMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO 251 03 62 87	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL UNDETERMINED ORGANISM 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SQUAMOUS CELL CARCINOMA, LARYNX DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from SEPT 10, 1967 to OCT 11, 1967 , that he (we) last saw the deceased alive on OCT 11, 1967 , and that death occurred at 4:35 AM , from causes and on the date stated above			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) KRISHNA V. S. RAO, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 10-14-67	
23c. NAME OF CEMETERY OR CREMATORY DRUCILLA CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) CHESTERFIELD, SOUTH CAROLINA	
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13482

13482

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville-8		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7915 Stevenson Rd.		e. STREET ADDRESS 7915 Stevenson Rd.	
3. NAME OF DECEASED (Type or print) First Leonard Middle (none) Last Hillman		4. DATE OF DEATH Month October Day 25 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1909
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months 03 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hillman		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 217-38-3479	
17. INFORMANT Mrs. Flora Hillman, 7915 Stevenson Rd., Pikesville 8, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the head (suicide) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		INTERVAL BETWEEN ONSET AND DEATH 2min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Deceased shot self between eyebrows with 4:10 gauge shot gun.	
20c. TIME OF INJURY Month, Day, Year before 4:05 p.m. 10-25-67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Pikesville Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples M.D.		22. DATE SIGNED 10-26-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/27/67	23c. NAME OF CEMETERY OR CREMATORY Balto Hebrew	23d. LOCATION (City or Town) (County) (State) Balto Md
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Garrison Md		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 27 1967			



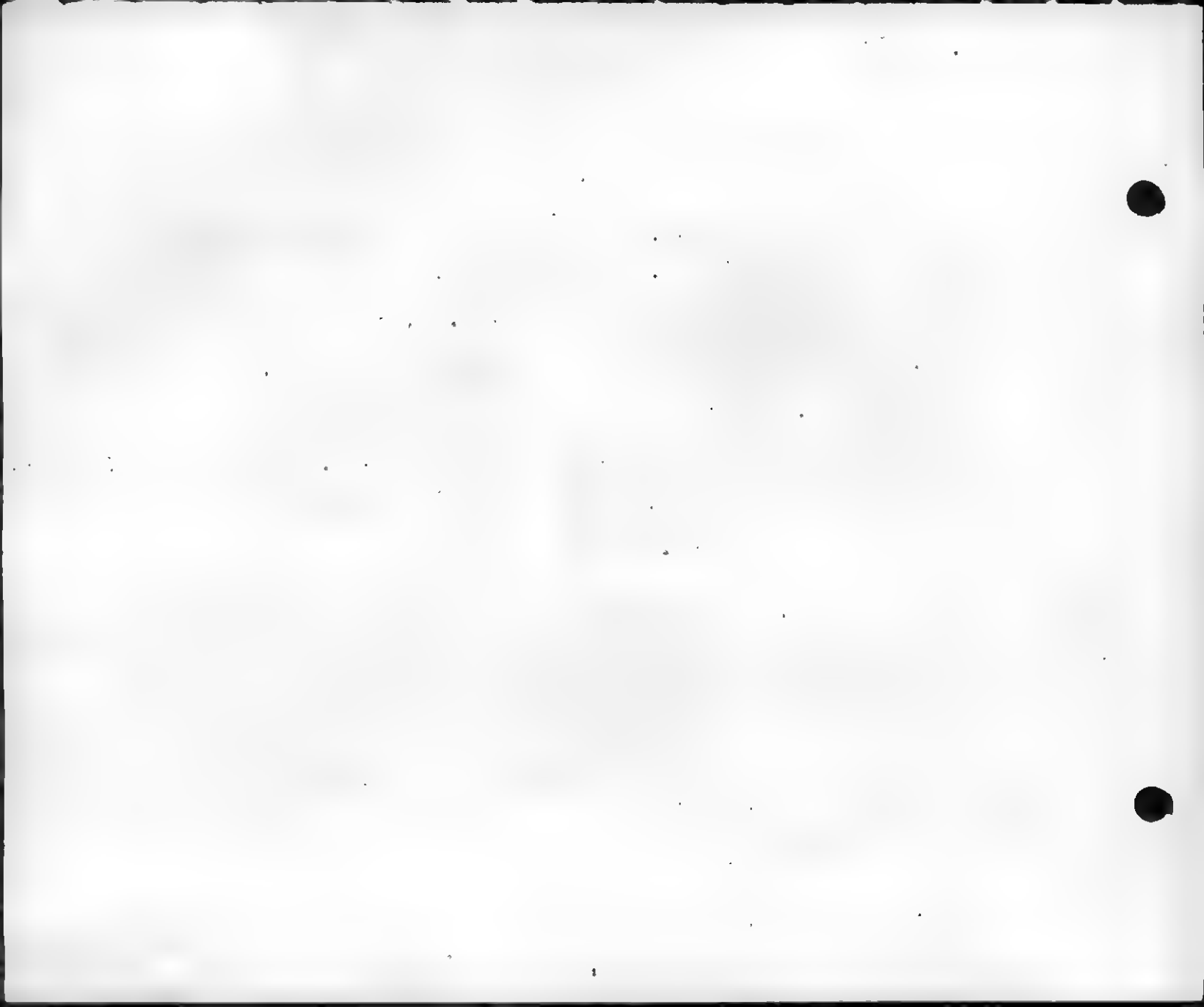
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b 77 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES NURSING HOME CATONSVILLE, MD.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 1916 Old Frederick Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle C. Last HOFFMAN SR.		4. DATE OF DEATH Month Oct. Day 29 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Poultryman		10b. KIND OF BUSINESS OR INDUSTRY Poultry	9. AGE (in years last birthday) 77 yrs. IF UNDER 1 YEAR: Months 2 Days 2 Hours 0 Min. IF UNDER 24 HRS.
11. BIRTHPLACE (County & State, or foreign country) Catonville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Hoffman		14. MOTHER'S MAIDEN NAME Katherine Kaiser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 213-32-0437	
17. INFORMANT Mrs Cecelia G. Hoffman		Address 1916 Old Frederick Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive heart failure DUE TO (b) ASCVD with severe cerebral ischemia DUE TO (c) cerebral ischemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 d. 2 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/17 , 19 63 to 10/29 , 19 67 , that (I) (we) last saw the deceased alive on 10/29 , 19 67 , and that death occurred at 3P M, from the causes and on the date stated above.			
22a. SIGNATURE James E. Rowe		22b. DATE SIGNED 10/30/67	
22c. PHYSICIAN'S NAME (Type) JAMES E. ROWE		22d. ADDRESS CATONSVILLE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov 2, 1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cent. Baltimore Maryland	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR STERLING FUNERAL ESTATE		25. REC'D BY REGISTRAR NOV 1 1967	
ADDRESS 736 Edm. Ave. Catonsville, Md.		25d. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

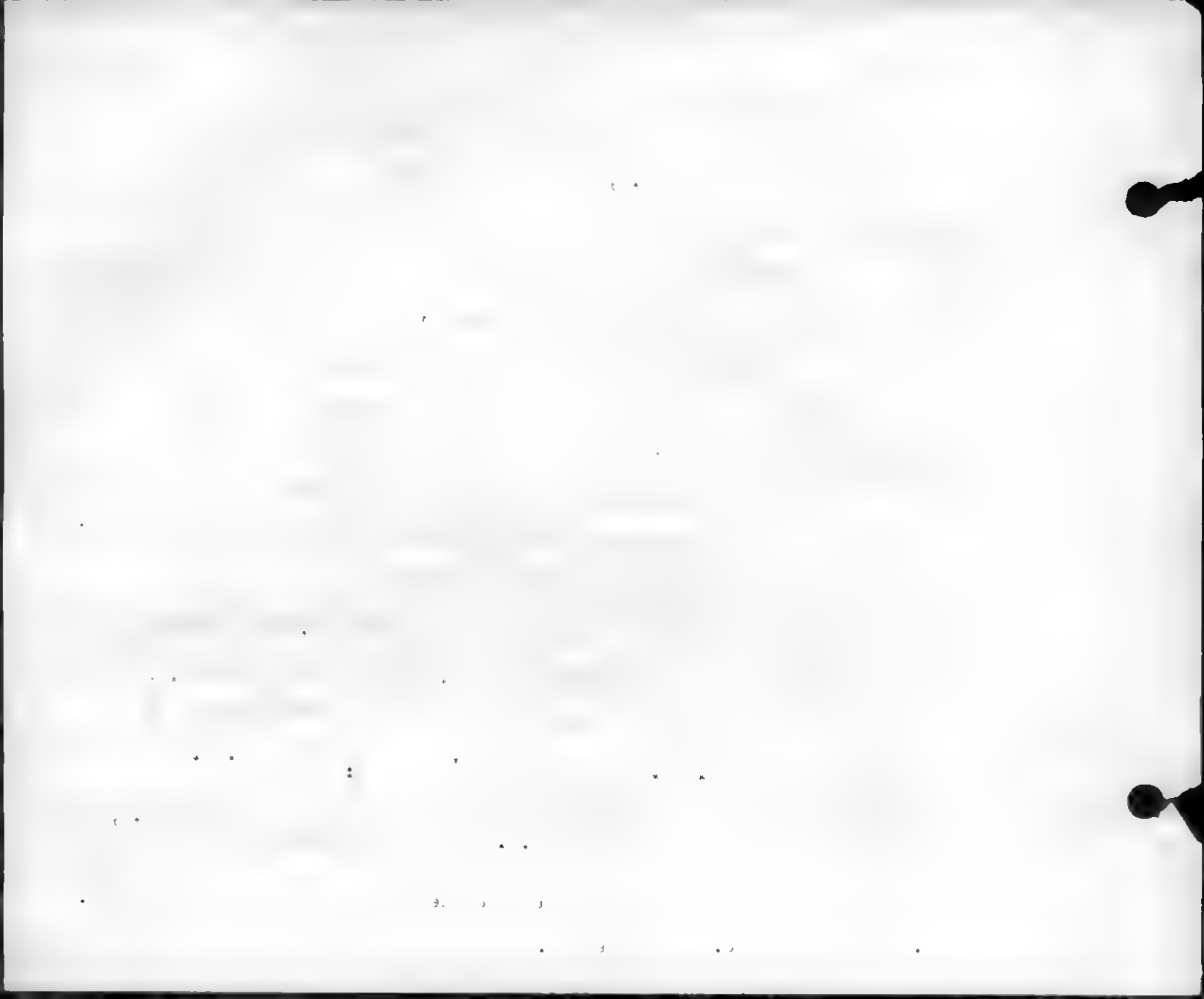
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13484

13489

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b Jan. 9, 1961 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Delaware b. COUNTY Delmar c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar d. STREET ADDRESS Jewel Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Allen Middle HOLDCRAFT Last 4. DATE OF DEATH Month October Day 8 Year 1967		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> May 23, 1904 9. AGE (In years last birthday) 63 yrs F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10b. KIND OF BUSINESS OR INDUSTRY 165-05-0258 11. BIRTHPLACE (County & State or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME XXXXXX Mary Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. XXXXXX 17. INFORMANT Spring Grove Records Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure (immediate) 4 DUE TO Arteriosclerotic Heart Disease, and aspiration due Vomiting Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) DUE TO Generalized Arteriosclerosis (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic Seizures due to Intracerebral Injury Oct. 1960 (operated) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 2" laceration in rt. temporal region on Oct. 2, 1967 (minor)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Body released by Dr. James Frederick Coroner (State)		21. I certify that (I) (this hospital) attended the deceased from Jan. 9, 1961 to Oct. 8, 1967 , that (I) (we) lost the deceased alive on Oct. 8, 1967 , and that death occurred at 4 P M , from causes and on the date stated above.	
22a. SIGNATURE Imre Kopits, M.D. 22b. DATE SIGNED Oct. 8, 1967		22c. PHYSICIAN'S NAME (Type) Imre Kopits, M.D. 22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/13/67 23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery 23d. LOCATION (City or Town) (County) (State) Montgomery County, Pa.		24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202 25a. REC'D BY REGISTRAR OCT 13 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

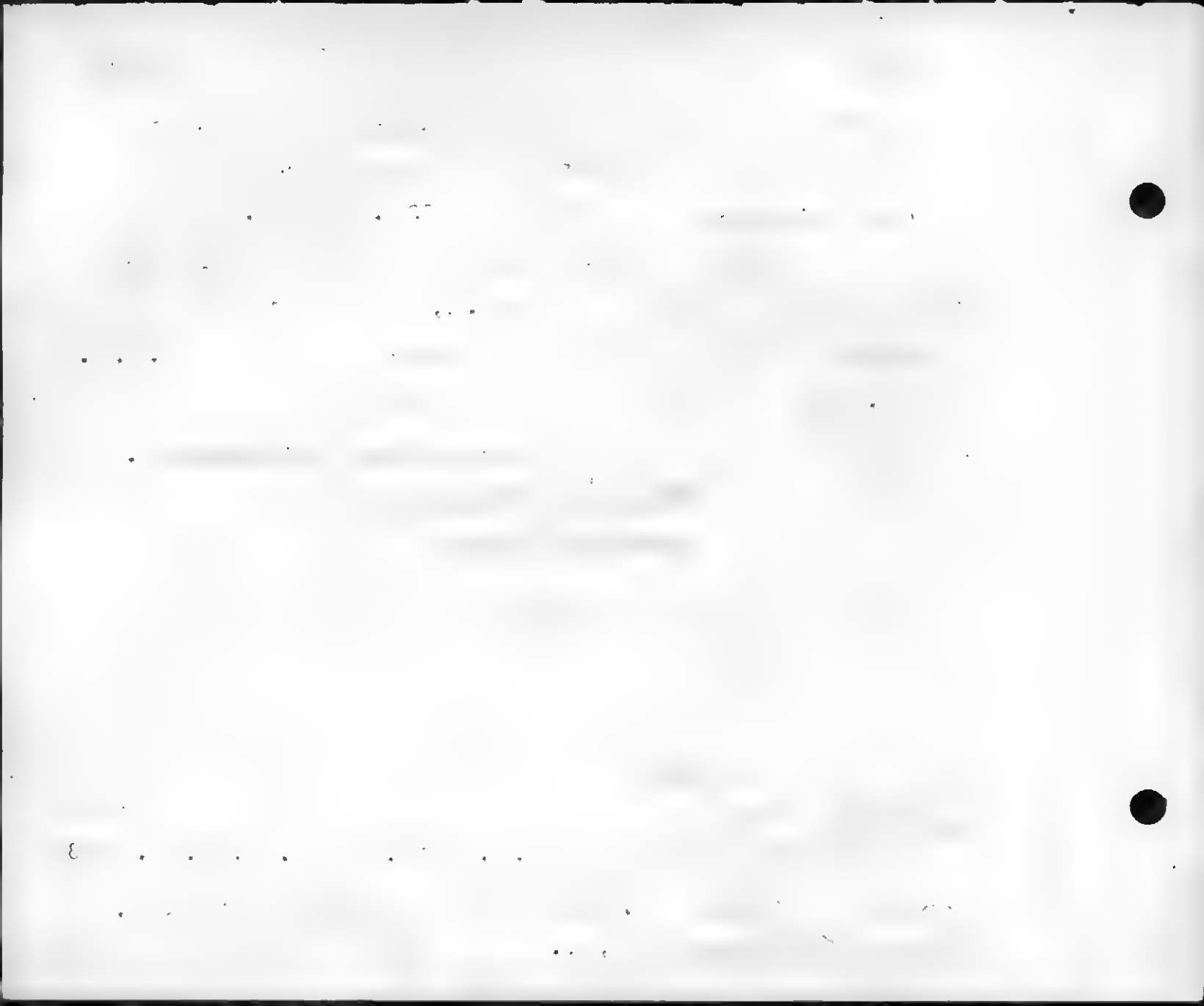


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

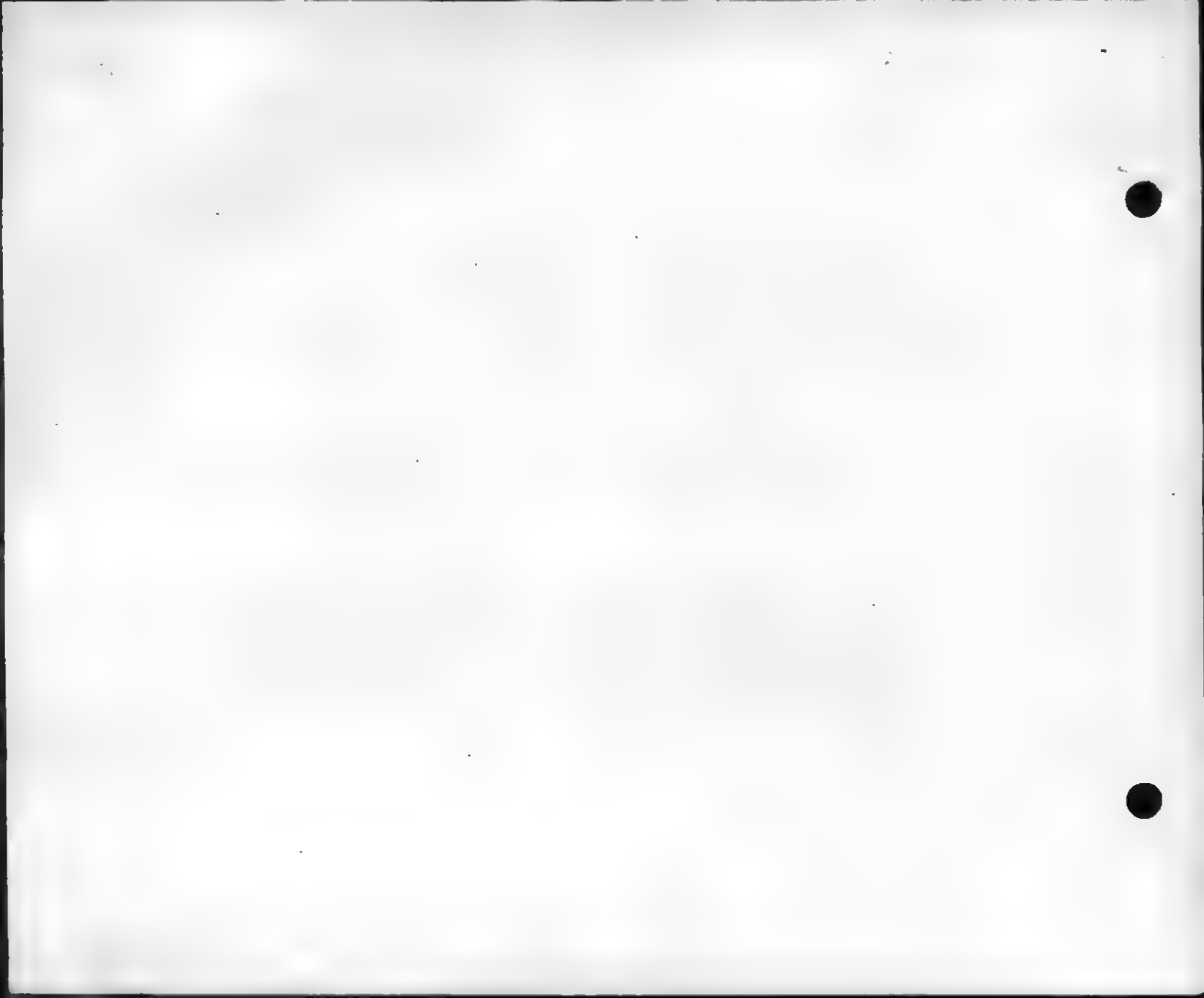
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13485					13490					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 3 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Armacost Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace d. STREET ADDRESS 810 S. Union Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Maude Middle Welsh Last Hollahan					4. DATE OF DEATH Month October Day 28 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1895		9. AGE (In years last birthday) 71 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Welsh					14. MOTHER'S MAIDEN NAME Jane McGee					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Fahey, 719 Chesapeake Dr.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 20 minutes 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to 10-28 , 19 67 that (I) (we) last saw the deceased alive on Aug 28 19 67 , and that death occurred at 10:28 M, from the causes and on the date stated above.										
22a. SIGNATURE Franklin Leslie					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10/30/67		
22c. PHYSICIAN'S NAME (Type) Franklin Leslie					22d. ADDRESS M. D. 302 E. 33rd St. Balto. Md. 21210					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/31/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cemetery			23d. LOCATION (City, town or county) (State) Havre de Grace, Md.		
24. FUNERAL DIRECTOR Pennington & Son, Havre de Grace, Md.					25a. REC'D BY REGISTRAR NOV 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13485						CERTIFICATE OF DEATH			13491		
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>						USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>					
c. LENGTH OF STAY IN 1b <u>Pikesville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Melford Manor Nursing Home</u>						d. STREET ADDRESS <u>4204 Melford Mill Road</u>					
3. NAME OF DECEASED (Type or print) <u>Eva</u> First Middle Last						DATE OF DEATH <u>Oct. 1 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-1-89</u>		9. AGE (in years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Cohen</u>						14. MOTHER'S MAIDEN NAME <u>Ethel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY # <u>050-18-3374</u>		17. INFORMANT <u>Morton J. Hollander</u> Address <u>7941 Longmeadow Road</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0 DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>67</u> , to <u>10/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/30</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph S. Blum</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/1/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM, MD</u>						22d. ADDRESS <u>1115 N. CALVERT ST BALTO-MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<u>Removal</u>		<u>October 1/67</u>		<u>Union Field</u>				<u>Brooklyn, New York</u>			
24. FUNERAL DIRECTOR <u>John E. Brown</u>						ADDRESS <u>6010 Reservoir Rd</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #2c & d Film #33 10/23/67 ph

13487

CERTIFICATE OF DEATH

13492

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 21221</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland-Towson Nursing Home 1111 Monticello Rd</u>		d STREET ADDRESS <u>5911 Glenkirk Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Elizabeth C. Hough</u>		4 DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-2-77</u> AGE (In years last birthday) <u>89</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11 BIRTHPLACE (City, State, or foreign country) <u>Baltimore Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>US</u>	
13 FATHER'S NAME <u>WALTER (Clement Jos. Meyer)</u>		14 MOTHER'S MAIDEN NAME <u>Meyers (Eliz. Deberding)</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>220-46-0070</u>	
17 INFORMANT <u>Mrs. Edw. Buckler, Jr.</u>		Address <u>-609 Hampton Lane-04</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stokes-Adams syndrome with cardiac arrest</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>64</u> , to <u>10/12</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/1</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> P.M., from causes and on the date stated above.			
22a SIGNATURE <u>Dr. F. Cox</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>10/16/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore</u>
24 FUNERAL DIRECTOR <u>MITCHELL-WIEDEFELD HOME-6500 York Rd. 21212</u>		25a REC'D BY REGISTRAR <u>OCT 18 1967</u> 25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

8-2-21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

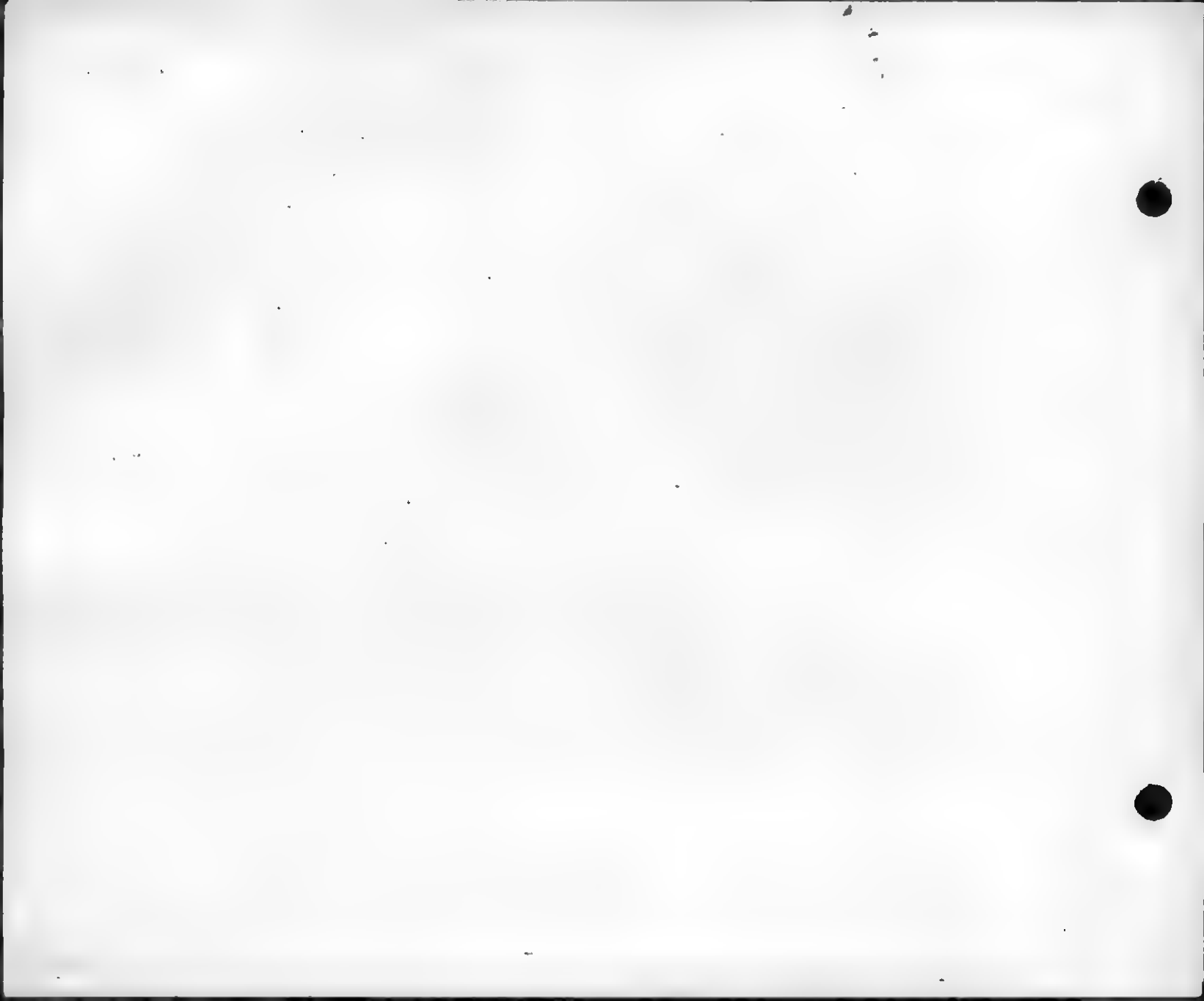
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13488

CERTIFICATE OF DEATH

13493

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>21223</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>		d. STREET ADDRESS <u>1835 FAIRMONT AVE.</u>	
3 NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>M</u> Last <u>HOUSTON</u>		4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-14-14</u>
9 AGE (In years last birthday) <u>52</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Day</u>		12 CITIZEN OF WHAT COUNTRY? <u>Day</u>	
13. FATHER'S NAME <u>Samuel Houston</u>		14. MOTHER'S MAIDEN NAME <u>Samuel Houston</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16 SOCIAL SECURITY NO <u>213-14-8743</u>	
17. INFORMANT <u>Samuel Houston</u>		Address <u>1835 Fairmount Ave</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Hypertension</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-20-1967</u> to <u>10-21-1967</u> , that (I) (we) last saw the deceased alive on <u>10-20-1967</u> , and that death occurred at <u>2:25 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Cesar Valle Caverio</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-21-67</u>
22c. PHYSICIAN'S NAME (Type) <u>CEGAR VALLE CAVERIO</u>		22d. ADDRESS <u>8029 Liberty Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Westport (Baltimore) Md</u>
24. FUNERAL DIRECTOR <u>Joseph Russ</u>		25a. REC'D BY REGISTRAR <u>2222 St. North Ave</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 24 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by medical attendant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

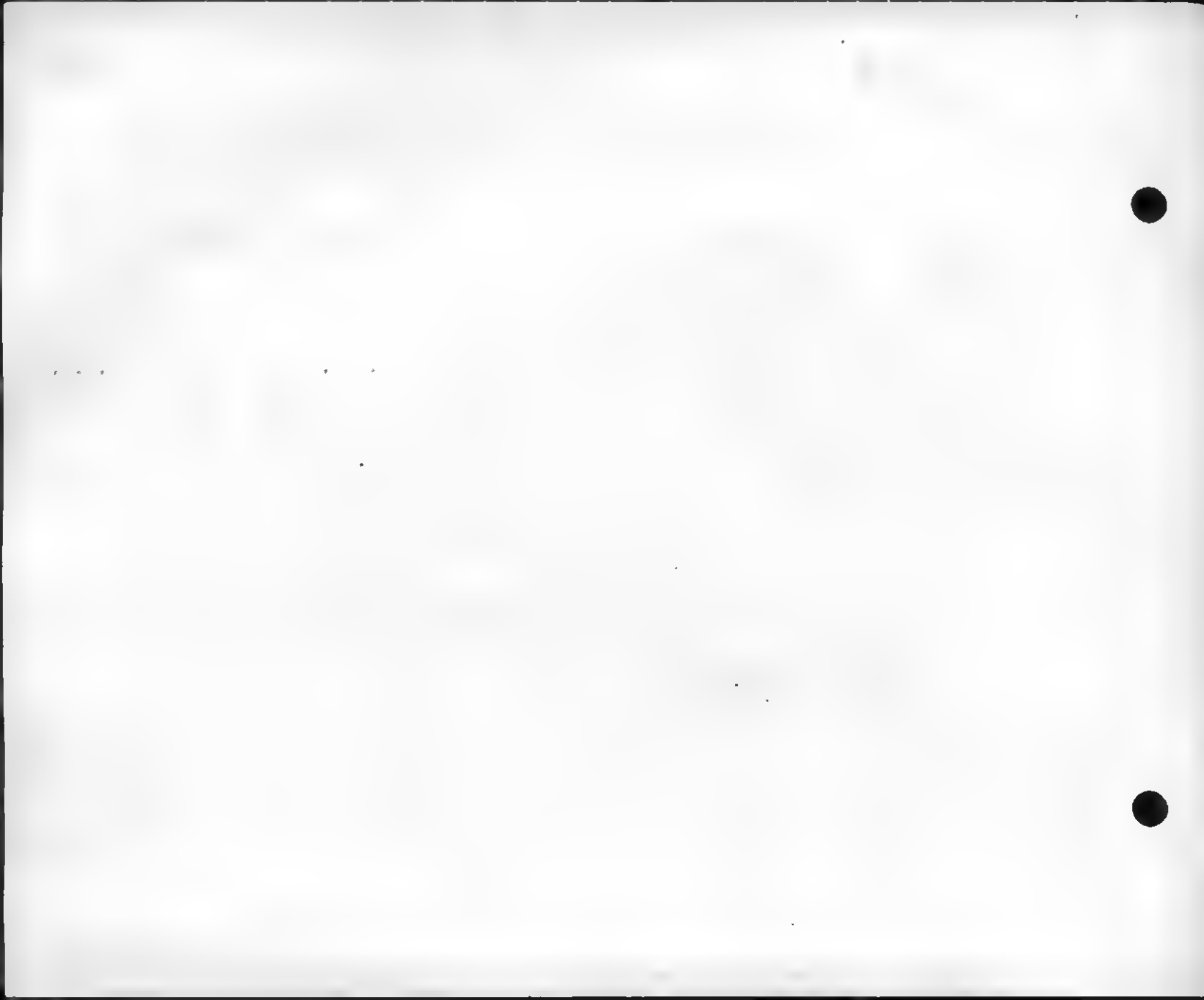
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13489

CERTIFICATE OF DEATH

13494

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c LENGTH OF STAY IN 1b Parkville,	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7818 Oak Avenue		d. STREET ADDRESS 7818 Oak Avenue 21234	
3 NAME OF DECEASED (Type or print) Amanda Wilhelmina Hughes		4. DATE OF DEATH Month 10 Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-20-1894
9 AGE (In years last birthday) 73 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Schuster	
14. MOTHER'S MAIDEN NAME Charlotte Ball		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT John Hughes Jr. 7818 Oak Avenue 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Rt. Acute. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) ± 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) NO INJURY	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 14 Oct 1967 , to 14 Oct 1967 , that (I) (we) last saw the deceased alive on 14 Oct 1967 , and that death occurred at 12:50 AM from causes and on the date stated above			
22a. SIGNATURE Edward L. J. Moiz, M.D.		22b. DATE SIGNED 16 Oct 67	
22c. PHYSICIAN'S NAME (Type) Edward L. J. Moiz, M.D.		22d. ADDRESS 7425 Hartford Rd. Balt. Md. 34	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-18-1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Co Md
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		25a. REC'D BY REGISTRAR OCT 18 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13470

13495

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON c. LENGTH OF STAY IN 1b 1 yr 3 mo 24 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOXLEIGH NURSING HOME		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 3219 McSHANE WAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CARL Middle NELSON Last HUNT		4 DATE OF DEATH Month 10 Day 26 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/89 9. AGE (In years last birthday) 88 10. IF UNDER 1 YEAR Months Days Hours Min 11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Has put out - Worker	
11 BIRTHPLACE (County & State, or foreign country) Marersville, Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME DANIEL HUNT		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16 SOCIAL SECURITY NO. unknown	
17 INFORMANT Mrs Anna Hunt		Address 3219 McShane Way, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction + DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) unknown			INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 7-3 , 19 66 , to 10 26 , 19 67 , that (1) (we) lost the deceased alive on 10 26 , 19 67 , and that death occurred at 5:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Daniel Miller M.D.		22b. DATE SIGNED 10 26 67	
22c. PHYSICIAN'S NAME (Type) Daniel Miller		22d. ADDRESS Clason Rd Camp Hill, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 30, 1967	George Washington Memorial Park	New Jersey
24. FUNERAL DIRECTOR Frank H. Dorell, Pikesville, Md.		25a REC'D BY REGISTRAR Charles Judge 25b REGISTRAR'S SIGNATURE DATE OCT 30 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



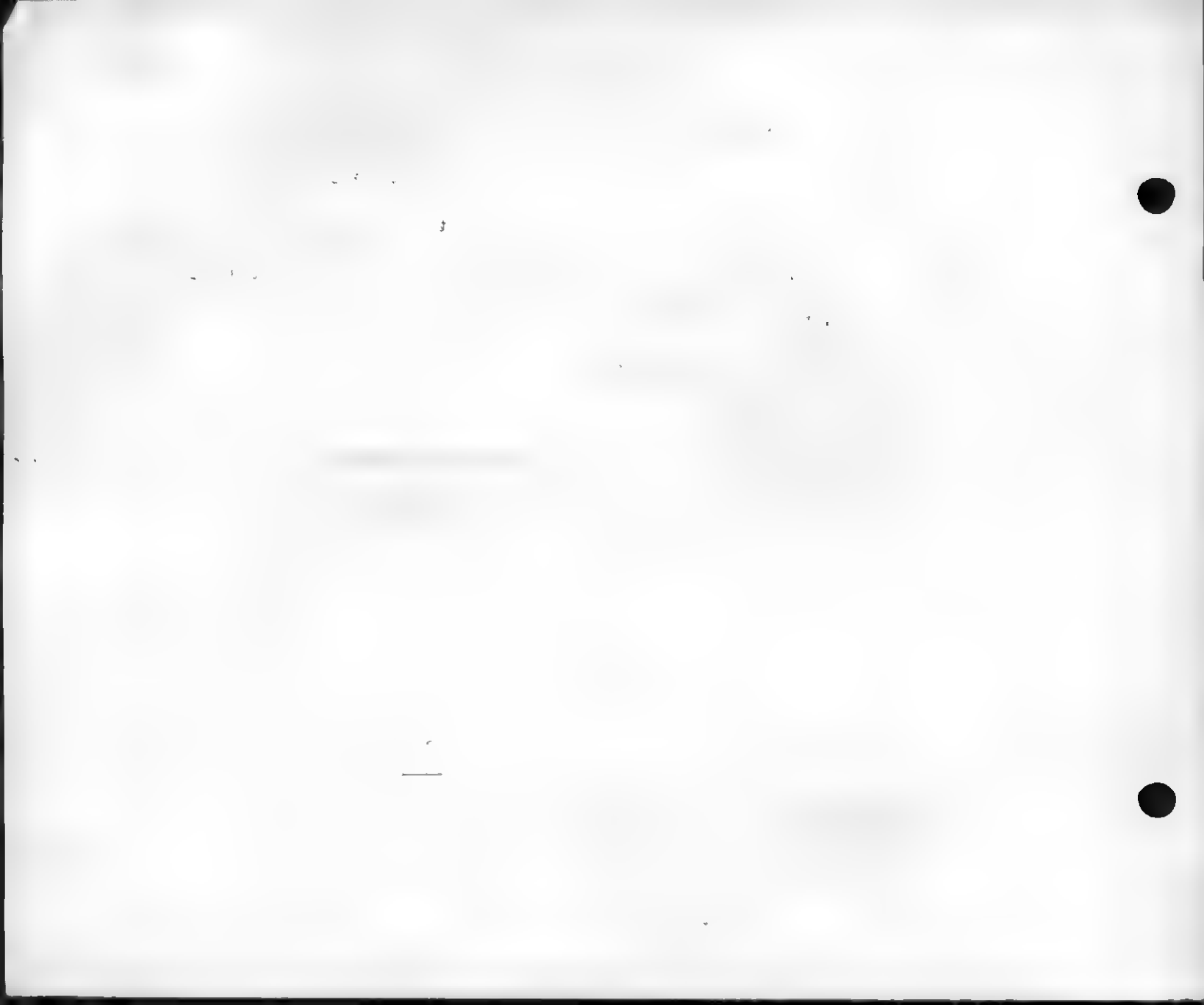
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

Items 18, 20a, 20b, f & 21 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13496									
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caltriders Lane					d. STREET ADDRESS Caltriders Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3 NAME OF DECEASED (Type or print) First ERVIN Middle REXFORD Last JACOBS					4 DATE OF DEATH Month October Day 11 Year 1967														
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH MAR 27 1937		9. AGE (In years lost birthday) 30 yrs		10. IF UNDER 1 YEAR Months 3 Days 10 Hours 11 Min 00		11. IF UNDER 24 HRS Hours 11 Min 00							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY WALL HANGER					10b. KIND OF BUSINESS OR INDUSTRY PAINT & BROADHURST					11. BIRTHPLACE (State or foreign country) CLINTON NC					12. CITIZEN OF WHAT COUNTRY? USA.				
13. FATHER'S NAME STEPHEN JACOBS					14. MOTHER'S MAIDEN NAME MARY AMMONS														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16. SOCIAL SECURITY NO 5470 58					17. INFORMANT MRS LARY MEADOWS 395A MAPLE AVE JESSUP MD					Address				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of the chest 117. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Subject shot accidentally														
20c. TIME OF INJURY Month, Day, Year Hour 4:00 10 11 19 67					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home					20f. (City or town) (County) (State) Reisterstown Balto Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>																			
ACTUAL SIGNATURE Edward F. Wilson					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22. DATE SIGNED 10/12/67									
EXAMINER'S NAME (Type) B STEWERT F. WILSON					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>														
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>														
					Address (Street, city, town, or county)														
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF OCT 15 1967					23c. NAME OF CEMETERY OR CREMATORY NEW BETHEL CEM					23d. LOCATION (City or town) (County) (State) CLINTON N.C.				
24. FUNERAL DIRECTOR THE VIPPEL BROS INC 1800 E LOMBARD ST					ADDRESS					25a. REC'D BY REG STRAR OCT 16 1967					25b. REGISTRAR'S SIGNATURE [Signature]				



13492

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

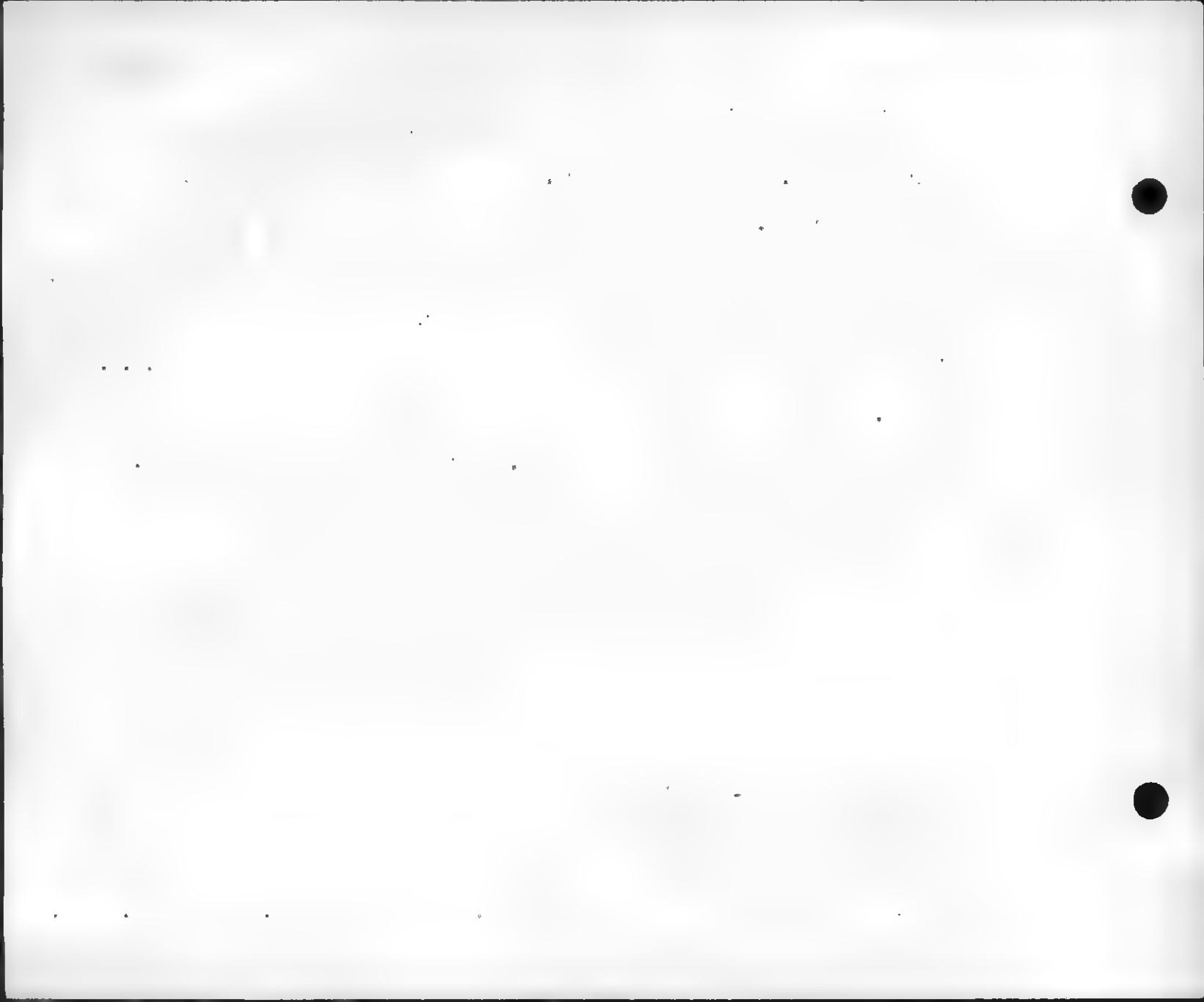
13497

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Baltimore		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto.		c LENGTH OF STAY IN TB 50 yrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4119 Taylor ave.			d STREET ADDRESS 4119 Taylor Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) John Roedel Jaeger			4 DATE OF DEATH Month 10 Day 4 Year 1967		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-14-1911	9 AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b KIND OF BUSINESS OR INDUSTRY Allied Research		11 BIRTHPLACE (State or foreign country) Maryland	
13 FATHER'S NAME John T. Jaeger			14 MOTHER'S MAIDEN NAME Annie Higdon		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO		17 INFORMANT Address E. Eleanor Jaeger 4119 Taylor Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street city town or county)		
23a BURIAL CREMATION, REINTERMENT (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial	10/9/67	Parkwood Cem.		Balto. Balto. Md.	
24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 2401 Belair Road			25a REC'D BY REGISTRAR DATE OCT 9 1967 25b REGISTRAR'S SIGNATURE Charles Jaeger		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13495

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BALTO. Co. Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> d. STREET ADDRESS <u>8343 Church Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Morris L</u>		4. DATE OF DEATH <u>10-14-1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-15-92</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harold Jaffe</u>		14. MOTHER'S MAIDEN NAME	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-34-1096</u>		17. INFORMANT Address <u>Mrs GEORGE SCHULMAN</u>	
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> DUE TO <u>451</u> Conditions, if any, which gave rise to immediate cause (b) <u>451</u> (c) <u>451</u> DUE TO <u>451</u> (e), stating the underlying cause last.		SAME INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>N.B. - Exploratory laparotomy - performed</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that (I) (this hospital) attended the deceased from Oct 13, 1967 **to** Oct 14, 1967 **that (I) (we) last saw the deceased alive on** Oct 14, 1967 **and that death occurred at** 3:10 AM **from the causes and on the date stated above.**

22a. SIGNATURE <u>Frank C. Caguin</u> M.D.		22b. DATE SIGNED <u>Oct 14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>FEDDOR C. CAGUIN</u>		22d. ADDRESS <u>8811 Liberty Rd. Randallstown Md</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodmen Circle</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
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24. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S. Lewis & Son, Inc</u>		25a. REC'D BY REGISTRAR <u>Frank J. Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Frank J. Judge</u>	
DATE <u>OCT 17 1967</u>					

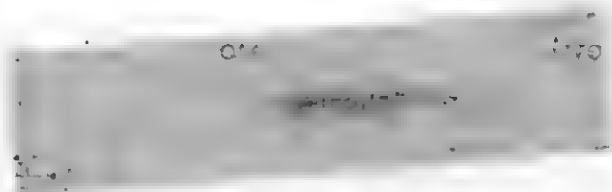
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Item 13 FilmG 434</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 13499</div> <div>CERTIFICATE OF DEATH</div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkton</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Carmel Road</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkton</u> d. STREET ADDRESS <u>Mt. Carmel Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Marie</u> Last <u>Jahnke</u>			4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1967</u>		5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>March 24, 1887</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Heilbronn A'N Germany</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>August Schmitt</u>					14. MOTHER'S MAIDEN NAME <u>Christine Bierbach</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES. (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Lillian P. Smith</u>			Address <u>(Same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO (b) <u>After Sudden G V Doses</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1964</u> , 19 <u>64</u> to <u>10/23</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/22</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>C. Herbert Mueller</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MEB. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/23/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MOELLER, Jr.</u>						22d. ADDRESS <u>PARKTON, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10/25/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>			23d. LOCATION (City, town or county) (State) <u>Parkville, Balto. Co. Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>						25a. REC'D BY REGISTRAR <u>OCT 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

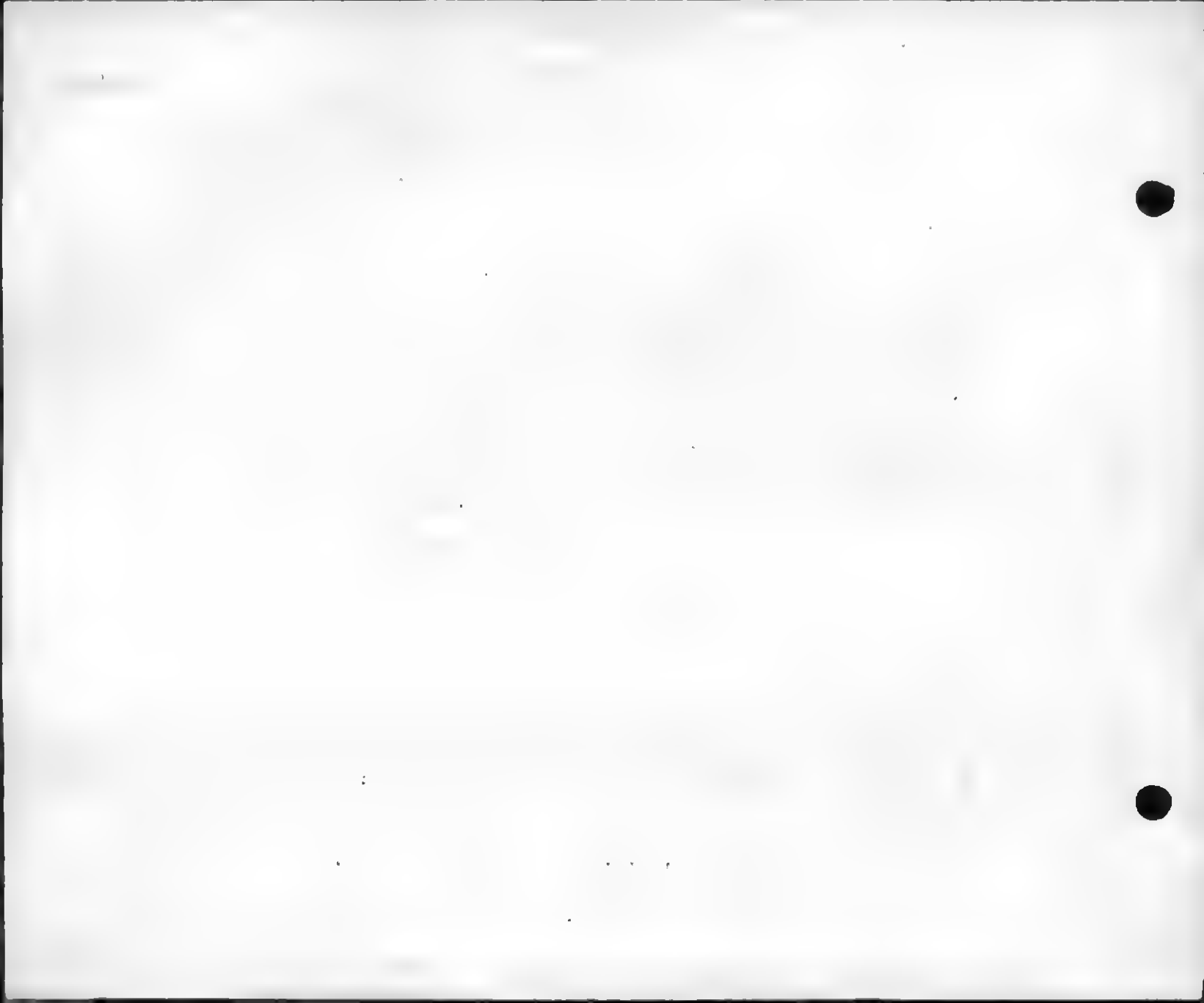
CERTIFICATE OF DEATH

13500

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa, 21085 d. STREET ADDRESS 2619 Green Spring Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Jennie Janda		4 DATE OF DEATH Month Day Year October 7 1967	
5 SEX Female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1887 April 6, 1886
9 AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vaclav MARES		14. MOTHER'S MAIDEN NAME Johanna	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220 44 843631	
17 INFORMANT Edwardo Janda		Address 2518 E. Monument St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Cerebro-Vascular Thrombosis DUE TO (c) Generalized Arteriosclerosis			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 30 , 1967, to October 7 1967 , that (I) (we) last saw the deceased alive on October 7 1967 , and that death occurred at 1:00a M, from causes and on the date stated above			
22a. SIGNATURE Beatriz P. Dizon M.D.		22b. DATE SIGNED October 7, 1967	
22c. PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Bohemian National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Philip E. Cuch		25a. REC'D BY REGISTRAR OCT 10 1967	
ADDRESS 1211 Chesaco Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12496

13501

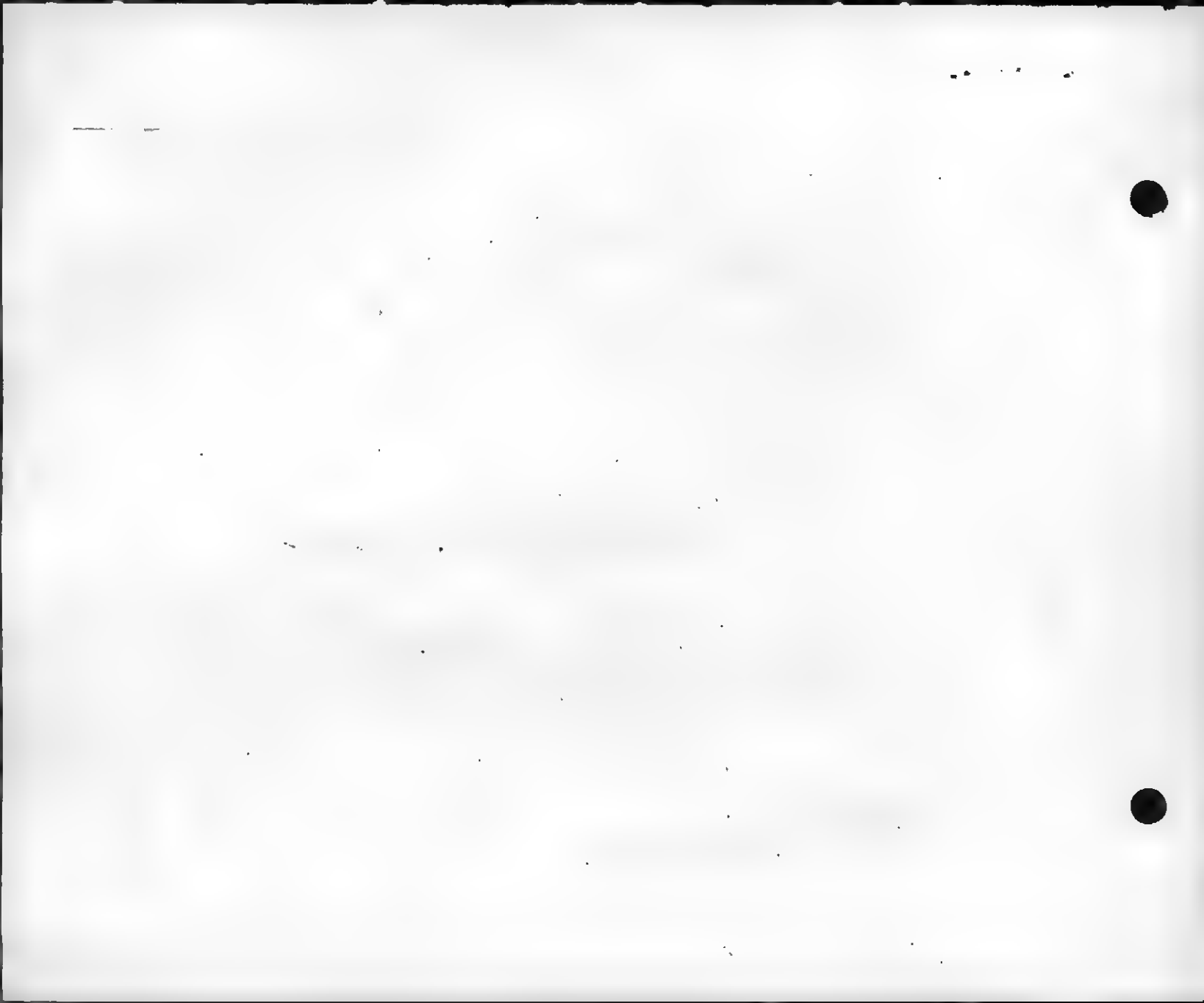
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - FARRISON</u>		c. LENGTH OF STAY IN TB <u>26 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forever Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Sophie Taslow</u>		4 DATE OF DEATH <u>10-30-67</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>RUMANIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Milton Greenberg</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>213-36-3210</u>	
17. INFORMANT <u>MR. Morris Taslow</u>		Address <u>XXXX 3608 CLARKS LANE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD, CVA suspected</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> to <u>Oct 30</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>Oct. 30, 1967</u> , and that death occurred at <u>1 P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Leon A. Sheer</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>LEON A. SHEER, MD</u>		22d. ADDRESS <u>6715 PARK HEIGHTS AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MARYLAND LODGE</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD</u>		25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

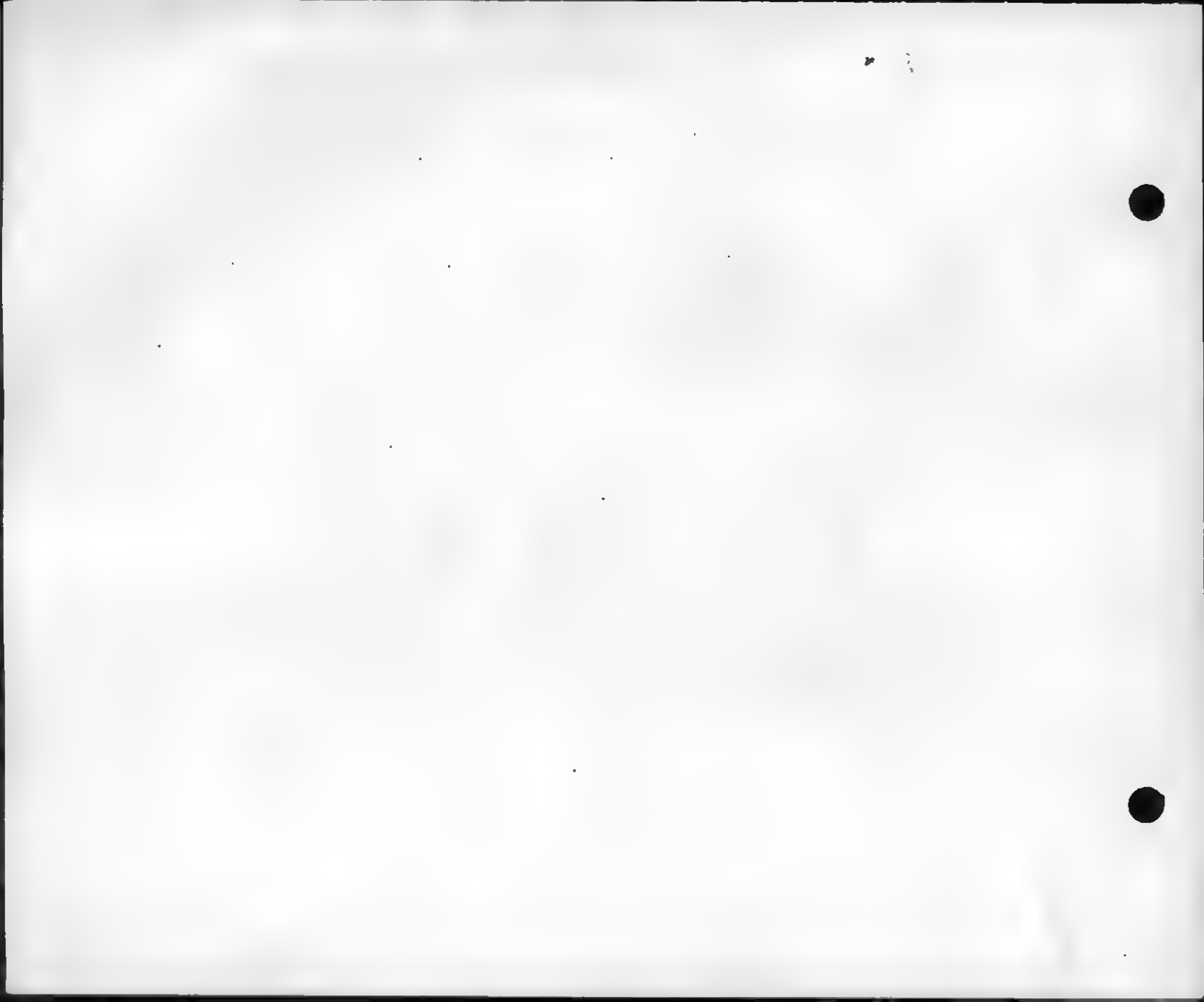
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13502											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>9 W. and Ave. (Balto. 25)</u> d. STREET ADDRESS <u>9 W. and Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>INIA</u> Middle <u>Jeffrey</u> Last <u>1</u>						4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/78</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>BENJAMIN BOYER</u>						14. MOTHER'S MAIDEN NAME <u>BARNESLEY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-46-2256</u>		17. INFORMANT <u>Patient's CHART</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> rssi DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio Vascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia involving whole (R) lung, DIABETES MELLITUS</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>Years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>67</u> , to <u>10/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/18</u> , 19 <u>67</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Derek A Bruce</u>						22b. DATE SIGNED <u>10/18</u>					
22c. PHYSICIAN'S NAME (Type) <u>DEREK A BRUCE</u>						22d. ADDRESS <u>G.B.M.C</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>10/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>			
24. FUNERAL DIRECTOR <u>Robert P. Singleton</u>						25a. REC'D BY REGISTRAR <u> </u>			25b. REGISTRAR'S SIGNATURE <u> </u>		
24. ADDRESS <u>Singleton Funeral Home / Glen Burnie, Md.</u>						DATE <u>OCT 20 1967</u>			25b. REGISTRAR'S SIGNATURE <u> </u>		



1. PLACE OF DEATH a. COUNTY		BALTIMORE COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		M.D.		b. COUNTY		BALTO. MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CATONVILLE, BALTO MARYLAND		c. LENGTH OF STAY IN 1b		12 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTO. MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		CATON RIDGE NURSING HOME		d. STREET ADDRESS		Unknown		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
		HELEN				JEROME		10		16 1967	
5. SEX		F		6. COLOR OR RACE		W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
								12/9/82		84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		LIBRARIAN		10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		BALTO. MD.	
13. FATHER'S NAME		UNKNOWN		14. MOTHER'S MAIDEN NAME		UNKNOWN		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		UNKNOWN		16. SOCIAL SECURITY NO.		214-54-2213		17. INFORMANT		John Fisher	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUPLICATE TO (b) DUPLICATE TO (c)		Pneumonia		INTERVAL BETWEEN ONSET AND DEATH		2 Days		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Arteriosclerotic Cardiovascular Disease									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/14/66, to 10/15, 1967, that (I) (we) las saw the deceased alive on 10/15 1967, and that death occurred at 3:00 PM, from the causes and on the date stated above		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. REC'D BY REGISTRAR	
		[Signature]		10/16/67		Frank E. Zichy		444 W Lane Ellwood City, Md		OCT 17 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR		25. REGISTRAR'S SIGNATURE	
Burial		Oct 16 1967		St. Mary's Cemetery		Baltimore, Maryland		Frank E. Zichy		Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13498

CERTIFICATE OF DEATH

13504

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institut an- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		c LENGTH OF STAY IN It		c CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) <u>Balto.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) <u>Shady Nook Nursing Home</u>			d STREET ADDRESS <u>5203 Gwyn Oak Ave.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Clinton P. Johnson</u>			4 DATE OF DEATH Month Day Year <u>October 28, 1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1880</u>		9 AGE (In years last birthday) <u>87</u> yrs
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>214-38-4647A</u>		17. INFORMANT Address <u>Carroll C. Woodrow 2621 Longwood Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, right lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> , 1967, to <u>10/28</u> , 1967, that (I) was last saw the deceased alive on <u>10/27</u> 1967, and that death occurred at <u>5 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>D. C. MacLaughlin</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED-DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>10/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. D. C. MacLaughlin</u>		22d ADDRESS <u>303 N. Rolling Rd. Balto. Md.</u>			
23a B. RIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>10/31/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d LOCATON (City or Town) (County) (State) <u>Balto. Md.</u>	
24 FUNERAL DIRECTOR <u>Witzke 4101 Edmondson Ave. Balto. Md.</u>		25a REC'D BY REG STRAR <u>OCT 30 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13500

13505

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY in 1b <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2751 Maryland Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Nessels</u> Last <u>Jones</u> 4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1967</u>				5. SEX <u>Fe</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>November 17, 1887</u> 9. AGE (In years last birthday) <u>79</u> 10. UNDER 1 YEAR Months _____ Days _____ 11. UNDER 24 HRS. Hours _____ Min _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Walter F.B. Nessels</u> 14. MOTHER'S MAIDEN NAME <u>Anna M. Nienke</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>213-03-5399</u> 17. INFORMANT <u>Records of Md. Masonic Home</u> Address _____									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> DUE TO <u>3 Anterior cerebral heart disease</u> (b) <u>3 Congestive heart disease</u> DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____								INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1965</u> , to <u>Oct 2, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 3, 1967</u> , and that death occurred at <u>11:45 AM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>James H. Hamel</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/3/67</u>				22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMM M.D.</u> 22d. ADDRESS <u>MASSONIC HOME, COCKEYSVILLE</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery, Cockeysville, Md.</u>		23d. LOCATION (City or Town) (County) (State) _____			
24. FUNERAL DIRECTOR <u>1000 Cord-Burke Town</u> ADDRESS <u>1050 York Rd, Towson, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 6 1967</u>		25b. REGISTRAR'S SIGNATURE _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 4, and 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13501

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13506

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2-203. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) XXXXX		c. LENGTH OF STAY IN 1b Twin River Chase (20)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1407 Eastern Avenue		d. STREET ADDRESS Box 324, Birdale Road	
3 NAME OF DECEASED (Type or print) JOSEPH A. JONES		4 DATE OF DEATH Month October Day 15 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/9/55
9 AGE (In years last birthday) 12 yrs		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 M n 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY --	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William A. Jones, Jr.		14 MOTHER'S MAIDEN NAME Edna McVicker	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. None	
17 INFORMANT William A. Jones, Jr.		Address Same	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 714.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Electrocuted by 11,000 volt Railroad Line	
20c. TIME OF INJURY Month, Day, Year 4:51 p.m. 10/15 1967		20d. NATURE OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Rail Road Tracks		20f. (City or town) (County) (State) Chase, Twin River, Balto., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 10/16/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/67	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or town) (County) (State) Glen Burnie, Md.	
24 FUNERAL DIRECTOR Brazdzinski Funeral Home 1407 Eastern Ave.		25a. REC'D BY REGISTRAR OCT 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

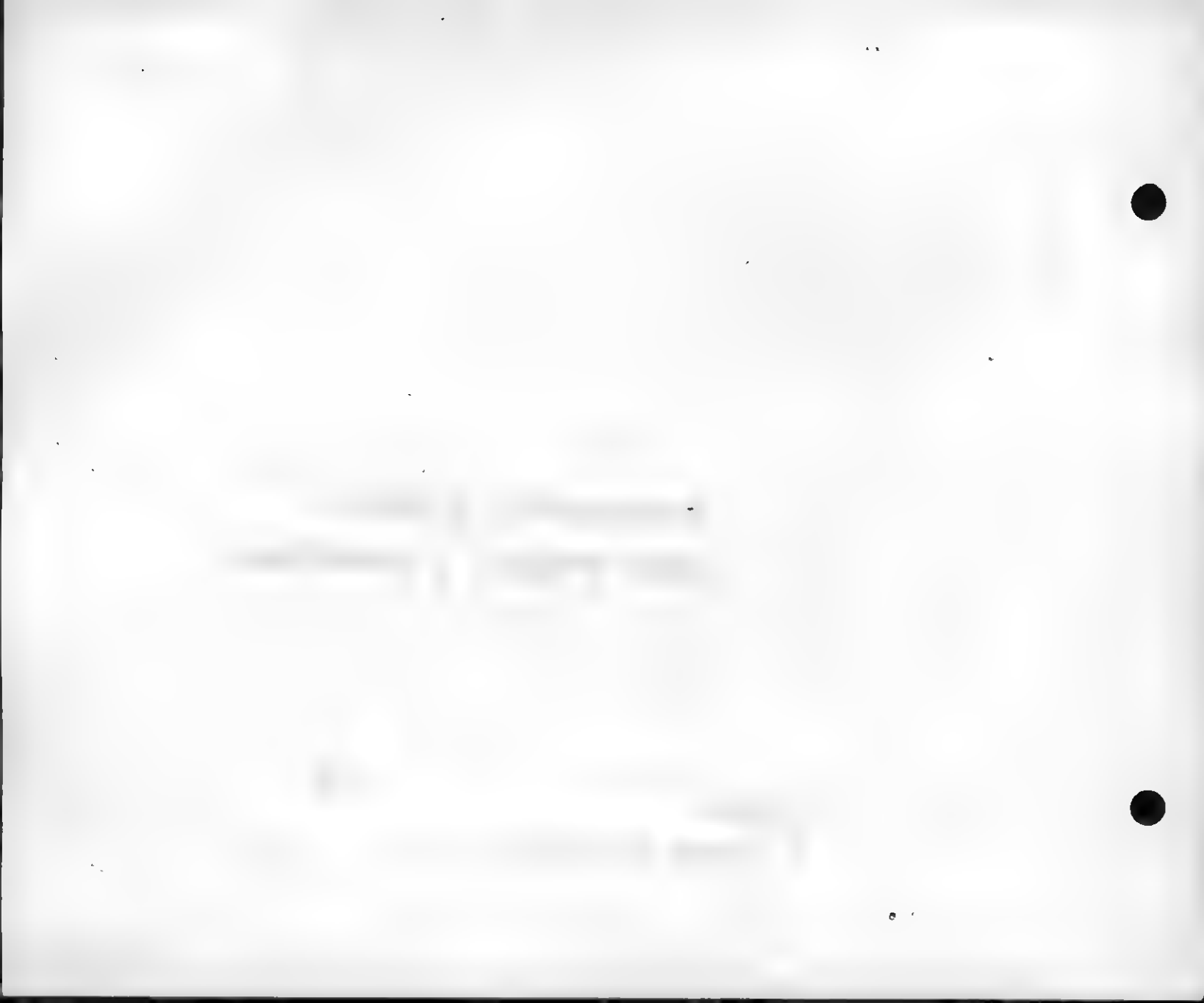
CERTIFICATE OF DEATH

13502

13507

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 16 <u>7 wks</u>		c. CITY OR TOWN <u>Conway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater BALTO med Center</u>		d. STREET ADDRESS <u>1001 Eastridge Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MAE</u> Last <u>KASNIC</u>		4 DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/14</u>
9 AGE (in years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Ambridge, Pa</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Kasarich</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kerchowicz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>211-32-1618</u>	
17. INFORMANT <u>Joseph T. Kasnic, 1001 Eastridge Ave</u>		Address <u>Conway, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO (b) <u>Brain metastasis of Breast Cancer</u> DUE TO (c) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/11/1967</u> to <u>10/26/1967</u> , that (I) (we) last saw the deceased alive on <u>10.26.1967</u> , and that death occurred at <u>LANSAM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Nasser Eftekhari</u>		22b. DATE SIGNED <u>10.26.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. NASSER EFTEKHARI</u>		22d. ADDRESS <u>GBMC - BALTO. Lawrence Co.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/28/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Little Beaver Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Little Beaver Township Pa</u>	
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13508

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1145 GRANVILLE RD</u>		d. STREET ADDRESS <u>1145 GRANVILLE RD</u>	
3 NAME OF DECEASED (Type or print) First <u>KATHERINE D.</u> Middle <u>KAVANAUGH</u> Last <u>KAVANAUGH</u>		4 DATE OF DEATH Month <u>OCT.</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>OCT. 27, 1890</u>
9 AGE (In years lost birthday) <u>77</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.F. & G.</u>
11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>MD.</u>	
13. FATHER'S NAME <u>JOHN J. KAVANAUGH</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGET MURRAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Mary Kavanagh - 1145 Granville Rd.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ABDOMINAL CIRCUMSCRIBED</u> <u>1111</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE - MINOR INFECTION</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <u> </u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>66</u> , to <u>10/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/30</u> , 19 <u>67</u> , and that death occurred at <u>4:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hall</u>		22b. DATE SIGNED <u>10/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hall M.D.</u>		22d. ADDRESS <u>8500 Edmonstone Ave. Balt. 18, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-3-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Foley, Conway & Co. - Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		25c. REGISTRAR'S NAME <u>Charles Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13509

Item #9 Film #394 10/27/67 ph

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS Locke Avenue Blvd.			
3. NAME OF DECEASED (Type or print) First Middle Last HAZEL Harrison KEEN				4. DATE OF DEATH Month Day Year 10 19 1967			
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/29/90	9. AGE (In years last birthday) 77 78/ yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY? US
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Issac Harrison				14. MOTHER'S MAIDEN NAME Gill ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None				16. SOCIAL SECURITY NO.			
17. INFORMANT Family records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis DUE TO (c) Carcinoma of colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/25, 1967, to 10/19 1967, that (I) (we) last saw the deceased alive on 10/19 67, and that death occurred at 3:35 a.m. from the causes and on the date stated above.							
22a. SIGNATURE John E. Adams				22b. DATE SIGNED 10/19/67			
22c. PHYSICIAN'S NAME (Type) John E. Adams, M. D.				22d. ADDRESS Greater Baltimore Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Oct. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Woodlawn, Balt. Co., Md.	
24. FUNERAL DIRECTOR John Burns Sons				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 23 1967			

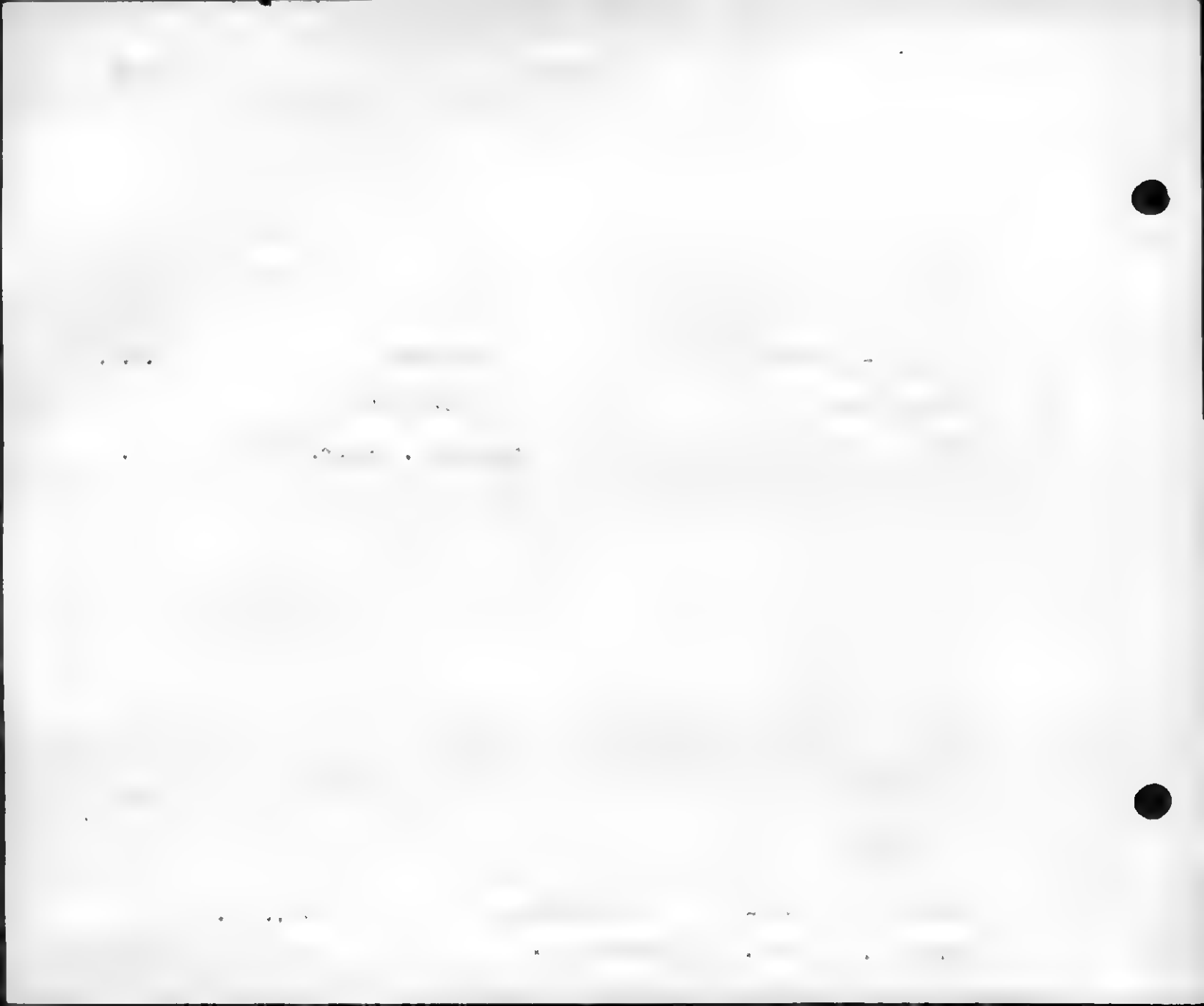


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13505									
CERTIFICATE OF DEATH									
13510									
1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> <u>Towson</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b COUNTY				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>					d STREET ADDRESS <u>1527 Winston Road #21212</u>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>M.</u> Last <u>Keller</u>					4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1967</u>				
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-19-1890</u>		9 AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13 FATHER'S NAME <u>Robert Stack</u>					14. MOTHER'S MAIDEN NAME <u>Julia Butler</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17 INFORMANT Address <u>Kathleen C. Keller, 1527 Winston Rd.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar pneumonia.</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>10-10-</u> , 19 <u>67</u> , to <u>10-10-</u> , 1967, that (H) (we) last saw the deceased alive on <u>10-10-</u> , 1967, and that death occurred at <u>11:30</u> , from causes and on the date stated above									
22a. SIGNATURE <u>[Signature]</u>					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> M.D. <u>[Signature]</u>			22b. DATE SIGNED <u>October 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Reynaldo Orjuela - Gomez, M.D.</u>					22d. ADDRESS <u>7620 York Road, Towson, Md. 21204</u>				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10-14-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>			23d LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>					25a REC'D BY REGISTRAR DATE <u>OCT 11 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

13506		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13511	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (If deceased lived, if institution on Residence before admission) a. STATE Maryland b. CITY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, 28		c. LENGTH OF STAY IN 1b since May 27, 67		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City - 19, Md. - Edgemere	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital			d. STREET ADDRESS 2121 Lodge Forest Dr		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Vida Frances M. KELLER			4. DATE OF DEATH Month Oct. Day 8 Year 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 3, 1896		9. AGE (In years last birthday) yrs 71
10a. USUAL OCCUPATION (Give kind of work done during most recent period) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Abraham Thomas			14. MOTHER'S MAIDEN NAME Lydia ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-12-5008		17. INFORMANT Address Spring Grove Record Catonsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease (Myocard. Infarction) DUE TO (c) Generalized Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain Tumor (Frontal lobe) (in evaluation.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) n o n e			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 27, 1967 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on October 8, 1967 , and that death occurred at 1: PM , from causes and on the date stated above					
22a. SIGNATURE <i>Imre Kopits</i> M.D.			22b. DATE SIGNED Oct. 8, 1967		22c. PHYSICIAN'S NAME (Type) Imre Kopits, M.D.
22d. ADDRESS Spring Grove Hospital, Catonsville, Md.			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MEDICAL CERTIFICATE

10

1.85

1.85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

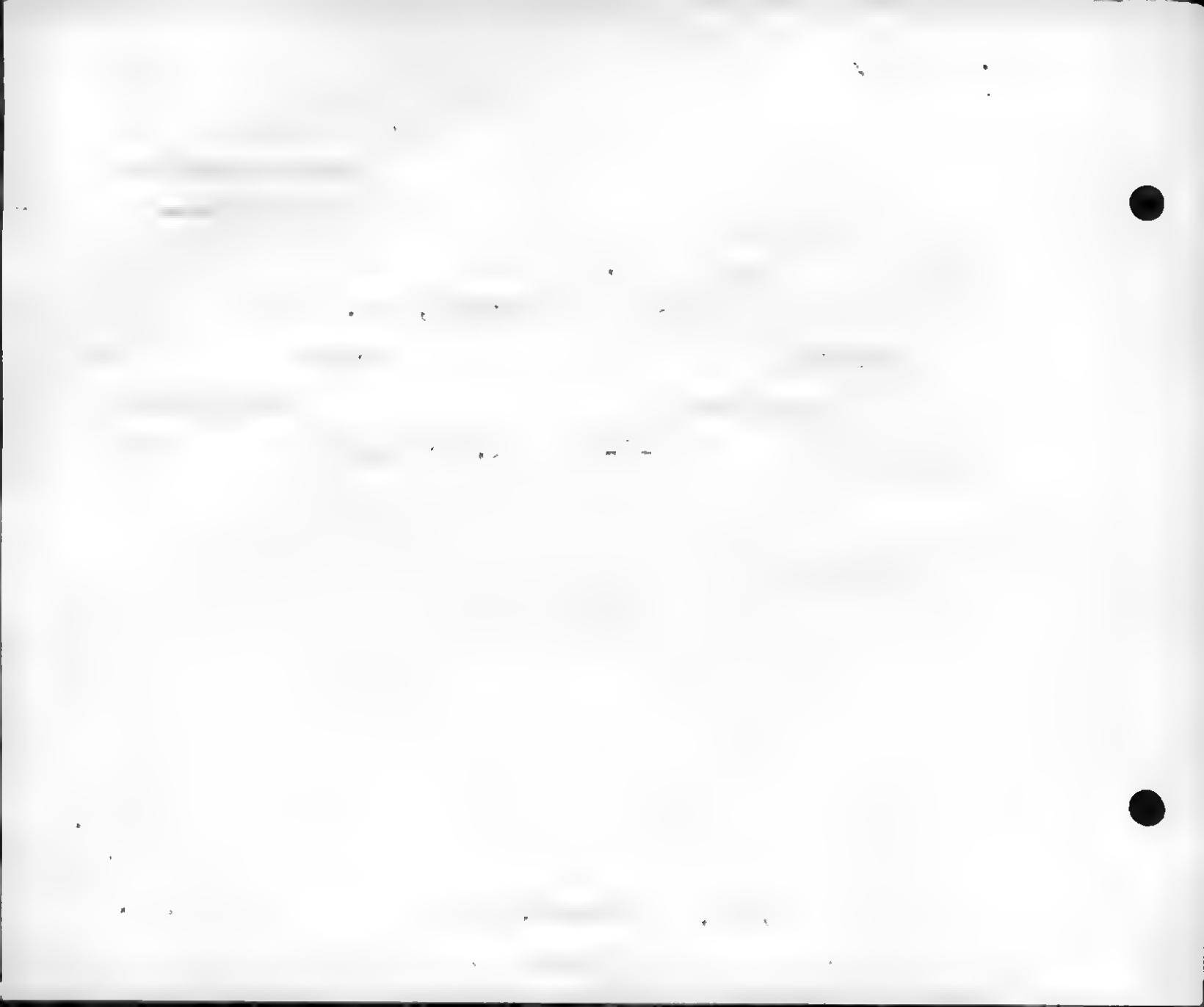
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13507

13512

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY _____	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		c LENGTH OF STAY IN 1b _____	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Armcast Nursing Home</u>		d STREET ADDRESS <u>1504 Lakeside Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Lillian E. Kelly</u>		4 DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 8, 1882.</u>
9 AGE (In years last birthday) <u>85</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b KIND OF BUSINESS OR INDUSTRY _____
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Eckardt</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Silkman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>217-14-5488</u>	
17 INFORMANT <u>Mrs. Oscar Hessler</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ARTERIO SCLEROTIC CV DISEASE</u> DUE TO (c) <u>ARTERIO SCLEROSIS - GENERALIZED</u>			INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>10 YEARS +</u> <u>11</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HEMIPLEGIA - CEREBRAL THROMBOSIS - OLD</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>66</u> , to <u>OCT 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 21</u> , 19 <u>67</u> , and that death occurred at <u>9:00 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Arthur Karfain</u>		22b DATE SIGNED <u>10/4/67.</u>	22c PHYSICIAN'S NAME (Type) <u>ARTHUR KARFAIN M.D.</u>
22d ADDRESS <u>1532 HAVENWOOD ROAD</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>10/7/67.</u>	23c NAME OF CEMETERY OR CREMATORY <u>Baltimore, Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a REC'D BY REGISTRAR DATE <u>OCT 5</u> 19 <u>67</u>	25b REGISTRAR'S SIGNATURE <u>Charles J. ...</u>



1

13508

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. CITY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST POINT</u>		c. LENGTH OF STAY IN 1b <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>524 FAIRVIEW</u>		d. STREET ADDRESS <u>629 WOODWARD</u>	
3. NAME OF DECEASED (Type or print) <u>MINNIE C. KIRCKHOFF</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 24, 1884</u>
9. AGE (in years lost birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN AULT</u>		14. MOTHER'S MAIDEN NAME <u>ANNA RUBB DELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>THELMA GOWER</u>		Address <u>524 FAIRVIEW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Hypertensive atherosclerotic heart disease</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 1967, to <u>10/25</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/25</u> , 1967, and that death occurred at <u>3:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>B. M. Oteyza</u>		22b. DATE SIGNED <u>10/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. M. Oteyza, M. D.</u>		22d. ADDRESS <u>1012 Old North Point Road 21224</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DAK LAWN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>J. G. CONNELLY SONS</u>		25a. REC'D BY REGISTRAR <u>300 MACE</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>OCT 30 1967</u>	



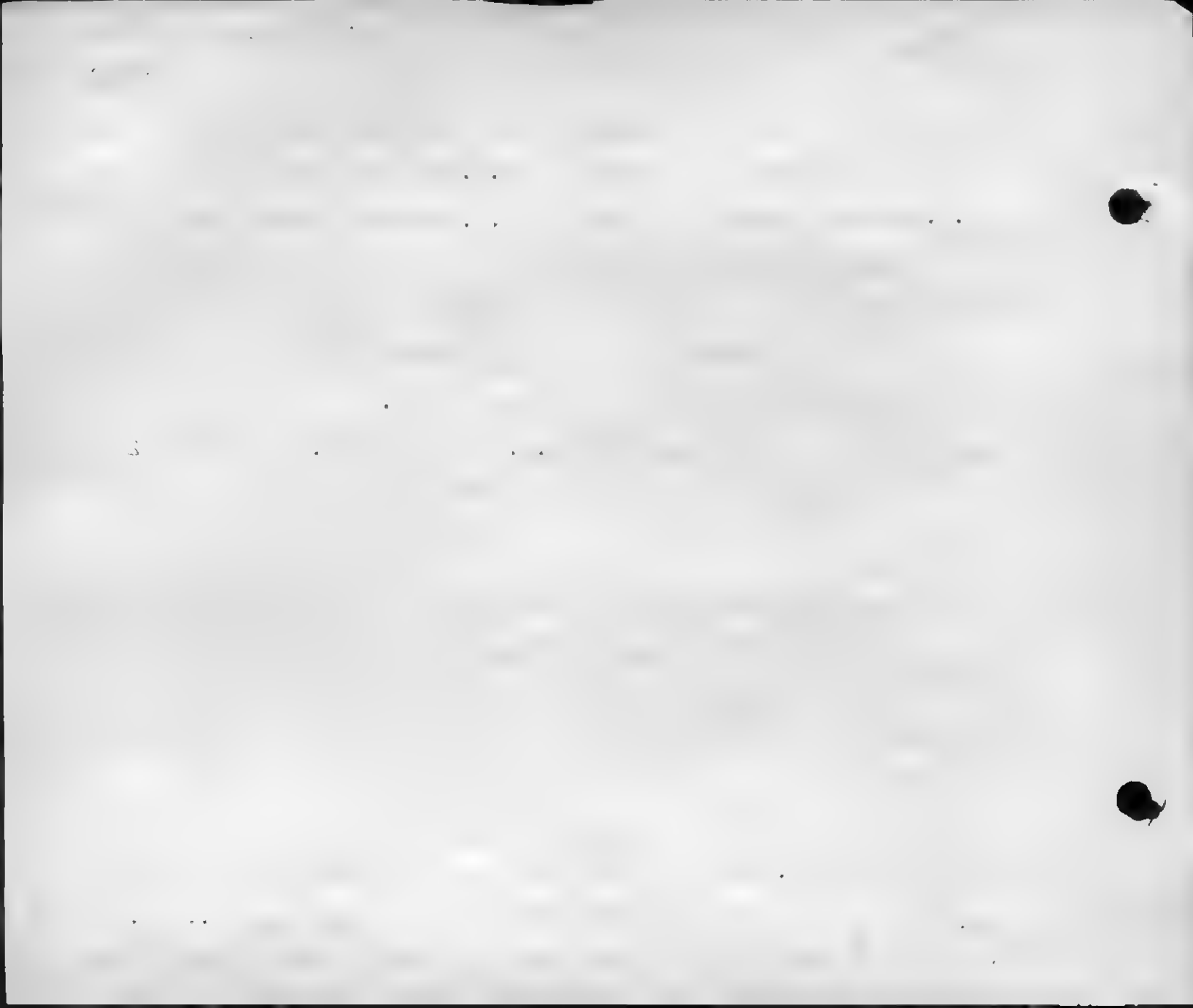
DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [redacted] is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13514

1. PLACE OF DEATH a. COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		a. STATE		b. COUNTY		BALTIMORE 21219					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		PENWOOD TERRACE		c. LENGTH OF STAY IN 16 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		/P.O. BOX 695		PENWOOD TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		P.O. BOX 695		PENWOOD TERRACE		d. STREET ADDRESS		P.O. BOX 695		PENWOOD TERRACE		f. DATE OF DEATH 10/29/1967					
3. NAME OF DECEASED (Type or print)		MARGIE WALTER KIRSCHNER		7. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/>		B. DATE OF BIRTH		12/1/1908		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
5. SEX		FEMALE		6. COLOR OR RACE		CAUCASIAN		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		HOUSEWIFE		11. BIRTHPLACE (State or foreign country)					
10b. KIND OF BUSINESS OR INDUSTRY		VIRGINIA		12. CITIZEN OF WHAT COUNTRY?		USA		13. FATHER'S NAME		CLAUDE WALTER		14. MOTHER'S MAIDEN NAME					
14. MOTHER'S MAIDEN NAME		UNK.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		NO		16. SOCIAL SECURITY NO.		219/28/9233		17. INFORMANT					
17. INFORMANT		J.H. KIRSCHNER, SR.		18. CAUSE OF DEATH [Enter only one cause part line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V Disease DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)		20c. TIME OF INJURY Month, Day, Year: 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		22e. (State)		23. FUNERAL DIRECTOR W. BROOKS BRADLEY, DUNDALK, MARYLAND		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR		W. BROOKS BRADLEY, DUNDALK, MARYLAND		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. DATE		24d. TIME		24e. SIGNATURE		24f. DATE		24g. TIME	



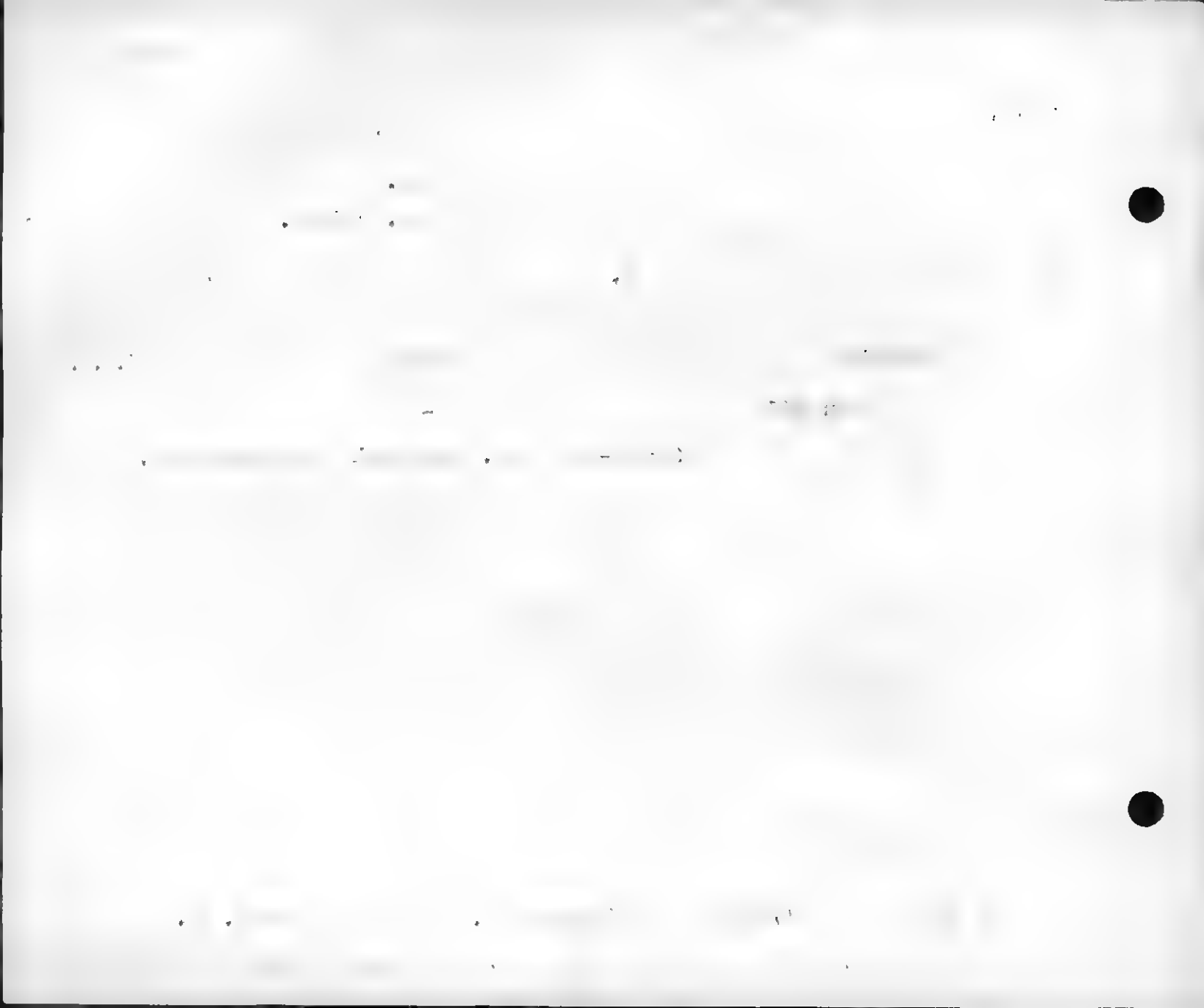
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Items #7, 8 & 9 Fill in #1393 10/6/67 ph
CERTIFICATE OF DEATH

13515

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>Balto.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 West Road (Dulaney-Towson N.H.)</u>				d. STREET ADDRESS <u>3501 St. Paul St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Loretta</u> Middle <u>H.</u> Last <u>Klenk</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan, 16, 1889</u>		9. AGE (in years last birthday) <u>78</u> yrs		10. UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hall</u>				14. MOTHER'S MAIDEN NAME <u>---</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>213-01-0525</u>		17. INFORMANT <u>Mr. Hall Klenk</u> Address <u>106 Midhurst Rd, I2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's Sarcoma, generalized</u> DUE TO (b) <u>emo.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>---</u>						INTERVA. BETWEEN ONSET AND DEATH <u>---</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5 May, 1967</u> to <u>2 Oct., 1967</u> that (I) (we) last saw the deceased alive on <u>2 Oct., 1967</u> , and that death occurred at <u>2:00 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Muse Jr.</u> M.D.				22b. DATE SIGNED <u>2 Oct. '67</u>		22c. PHYSICIAN'S NAME (Type) <u>---</u>	
22d. ADDRESS <u>2725 N. Charles St. (15)</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

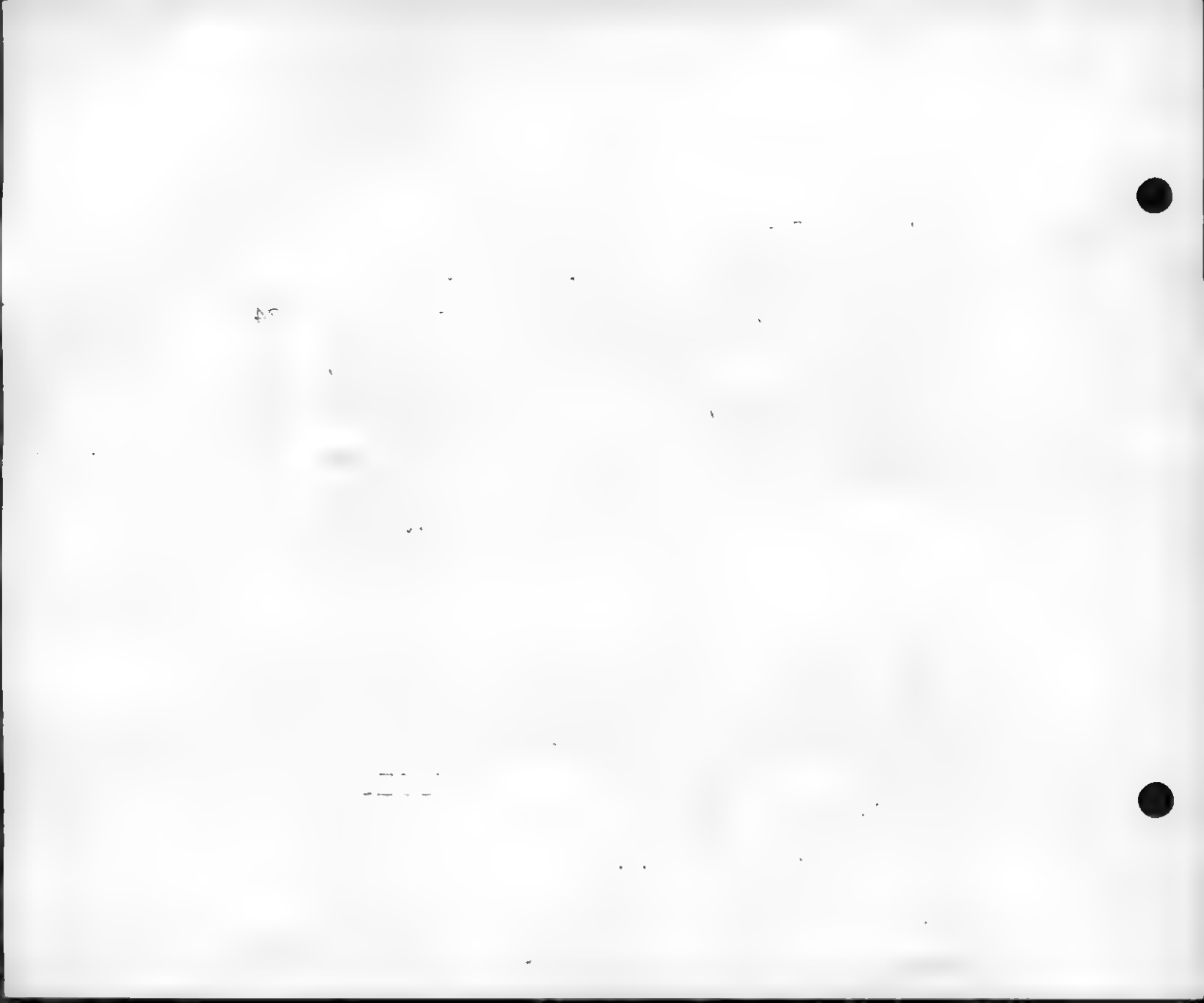
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b NONE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Amoco Station - Taylor & Loch Raven		e. STREET ADDRESS 30th Street 1833 E.	
3. NAME OF DECEASED (Type or print) First ROBERT Middle E. Last KNOX		4. DATE OF DEATH Month October Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1933
9. AGE (In years last birthday) 34		10. IF UNDER 1 YEAR Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY AMOCO STATION	
11. BIRTHPLACE (State or foreign, country) WILMINGTON, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT E. KNOX, SR.		14. MOTHER'S MAIDEN NAME LOSSIE SIDEBERRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. Walter Rhen		Address 6901 Lock Raven Blvd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium DUE TO stab wound of chest involving the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — (c) —			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Stabbed during a fight	
20c. TIME OF INJURY Month, Day, Year 3:00 PM 10/29 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> Amoco Station	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 10/29/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-2-67	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Pl.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Mortimer Dyett F.H.		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
ADDRESS 1701 LAURENS ST.		25b. REGISTRAR'S SIGNATURE James J. Jones	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12512

CERTIFICATE OF DEATH

13517

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 1200 BALTIMORE MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MED. CENTER		d. STREET ADDRESS 1200 TUGWELL DR.	
3. NAME OF DECEASED (Type or print) First JULIA Middle B. Last KOCHER		4. DATE OF DEATH Month October Day 21 Year 1967	
5. SEX Female	6. COLOR OR RACE W. C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-87
9. AGE (In years last birthday) 80 yrs.		10. UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MATHEW BAZEK		14. MOTHER'S MAIDEN NAME XXXXXXXXXX Katherine Scheick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-30-5096	
17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of vulva w 100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) Liver + peritoneal metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombophlebitis legs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-19- , 1967 , to 10-21 , 1967 that (I) (we) last saw the deceased alive on 10-21 , 1967 , and that death occurred at 2:25 AM , from causes and on the date stated above.			
22a. SIGNATURE Jesse M. De Leon M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jesse M. De Leon, MD		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR 6500 York Rd.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 24 1967	
Balto., Md. 21212			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13513

13518

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b COUNTY Baltimore	
c LENGTH OF STAY IN 1b 2 1/2		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Beltway I695 1/4 ml N. of Alt.		d STREET ADDRESS 2805 Frederick Ave.	
3 NAME OF DECEASED (Type or print) ESTELLE		4 DATE OF DEATH October 6 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1940
9 AGE (In years lost birthday) yrs 27		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES WOMEN		10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
11 BIRTHPLACE (State or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JAMES LADD		14 MOTHER'S MAIDEN NAME LUCILLE MORRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 218-36-6118	
17. INFORMANT JAMES LADD		Address 416 S. STRICKER ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. DUE TO (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Subject, passenger in car into tractor trailer			
20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject, passenger in car into tractor trailer	
20c. TIME OF INJURY Month Day, Year Hour a.m. 1:20 PM 10 6 19 67		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Street		20f. (City or town) (County) (State) Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		22. DATE SIGNED October 6, 1967	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		23. LOCATION (City or town) (County) (State) BALTIMORE-MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-11-67	
23c. NAME OF CEMETERY OR CREMATORY LONDON PARK		23d. LOCATION (City or town) (County) (State) BALTIMORE-MARYLAND	
24. FUNERAL DIRECTOR WALTERS FUNERAL HOME		25a. REC'D BY REGISTRAR PRATT+STRICKER	
25b. REGISTRAR'S SIGNATURE James Ladd		DATE OCT 13 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

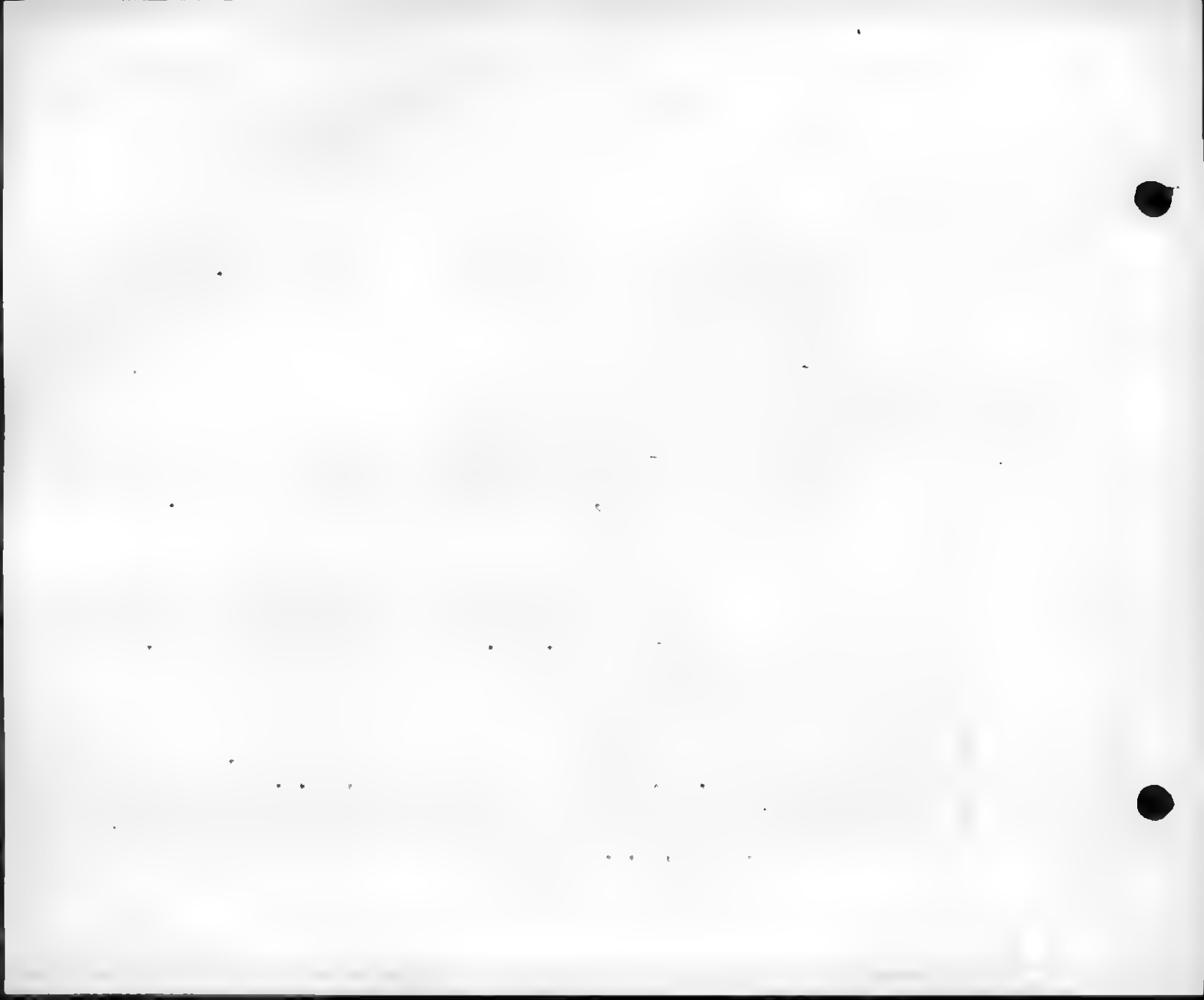
13514

CERTIFICATE OF DEATH

13519

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 3mth21dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gwynn Oak, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3014 Fairview Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Max Middle Krout Last Krout				4. DATE OF DEATH Month Oct. Day 26 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1894		9. AGE (In years last birthday) yrs 73	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) grocery store		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Solomon Krout				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unk		16. SOCIAL SECURITY NO. 218-38-3902		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral, lobar, organism undeter. 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Ht. Dis.; bacteremia with shock asso.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from July 3, 1967 , to Oct. 26, 1967 , that (1) (two) last saw the deceased alive on Oct. 26, 1967 , and that death occurred at 4:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young, M.D.</i> M.D.				22b. DATE SIGNED 10/26/67 5:50 PM		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/29/67	23c. NAME OF CEMETERY OR CREMATORY Charles Emerson City Chm		23d. LOCATION (City or Town) (County) (State) Balto Md			
24. FUNERAL DIRECTOR SYLVAN LEWIS & SON GARRISON, M.D.				25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13515
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13521

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b Years TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 609 VALLEY LANE		d. STREET ADDRESS 609 VALLEY LANE	
3. NAME OF DECEASED (Type or print) JESSE J. M. LAIRD		4. DATE OF DEATH OCT. 15 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 7 1904
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) NO		16. SOCIAL SECURITY NO 217-1632254	
17. INFORMANT Dr. George McLaren, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 4211 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		22. DATE SIGNED 10/15/67	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		DEPUTY MEDICAL EXAMINER Charles Judge MD. Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Towson, Maryland 21204
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR OCT 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13516

CERTIFICATE OF DEATH

13522

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 16 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21218 d. STREET ADDRESS 3800 Monterey Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Joseph LANE		4. DATE OF DEATH Month Day Year October 30, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-1896
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min 0 0 0 0	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY LAW	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PETER LASTOWSKI		14. MOTHER'S MAIDEN NAME CATHERINE KISINGOLD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W. W. I		16. SOCIAL SECURITY NO. W. W. I	
17. INFORMANT W. W. I		Address 3800 Monterey Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive anterior septal myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pulmonary thrombo embolism.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-22- , 19 67 , to 10-30- , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-30- , 19 67 , and that death occurred at 7 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED October 30, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-2-67	
23c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL Cem.		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR Stanley Miller - 2334 Jefferson St.		25a. REC'D BY REGISTRAR DATE NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12512 CERTIFICATE OF DEATH 13523									
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12					b. COUNTY Baltimore				
c. LENGTH OF STAY IN 1b ?					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 303 Regester Ave.					d. STREET ADDRESS 303 Regester Ave.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Mollie G. Lane					4. DATE OF DEATH Month Day Year 10 5 1967				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-28-1892		9. AGE (In years last birthday) 75 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore		
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 215-03-7958				
17. INFORMANT Address Dr. Charles Reier 6701 York Rd.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic aneurysm 457X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 4 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July, 1936, to 5 Oct, 1967, that (I) (we) last saw the deceased alive on 5 Oct 1967, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE Charles H. Reier					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5 Oct 67		
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Reier					22d. ADDRESS 6701 York Rd., Baltimore 12				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-7-67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town or county) (State) Woodlawn Balto. Co.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd., Balto.					25a. REC'D BY REGISTRAR OCT 6 1967				
					25b. REGISTRAR'S SIGNATURE Charles Jenkins				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13524

12518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204		d. STREET ADDRESS 9001 Lodi Road, Balto., Md.	
3. NAME OF DECEASED (Type or print) First EDWARD Middle C. Last LARTER		4. DATE OF DEATH Month October Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-10
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY Govans Chev.	
11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Larter		14. MOTHER'S MAIDEN NAME Annie Cromwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W W 11		16. SOCIAL SECURITY NO. 174-05-3535	
17. INFORMANT Mrs Jean K. Larter		9001 Lodi Road 21246	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction - old and recent 4201 "DUE TO" Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from 10-21 , 19 67 , to 10-29 , 19 67 , (we) last saw the deceased alive on 10-29 , 19 67 , and that death occurred at 3:12 PM , from causes and on the date stated above.			
22a. SIGNATURE William		22b. DATE SIGNED 10-29-67	
22c. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-1-1967	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Balto, Md.
24. FUNERAL DIRECTOR Lassiter Funeral Home 2701 Belden Road		25a. REC'D BY REGISTRAR NOV 1 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13519
CERTIFICATE OF DEATH
13525

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS 1720 Wadsworth Way			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth I. Lascola				4. DATE OF DEATH Month Day Year October 18 19 67			
5. SEX F		6. COLOR OR RACE Caus		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/27/07	
9. AGE (in years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? —				13. FATHER'S NAME unknown			
14. MOTHER'S MAIDEN NAME unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —			
16. SOCIAL SECURITY NO. —				17. INFORMANT Husband (Vincent Lascola)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Lung Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct 12, 19 67 to Oct 18, 19 67 , that (I) (we) last saw the deceased alive on Oct 19, 19 67 , and that death occurred at 8 A M, from the causes and on the date stated above.					
22a. SIGNATURE Michael Byerly				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) H Paul Byerly	
22d. ADDRESS 5820 York Rd		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		21 Oct 67		New Cathedral		Baltimore Md	
24. FUNERAL DIRECTOR Witzke Funeral Dir 4101 Emden				25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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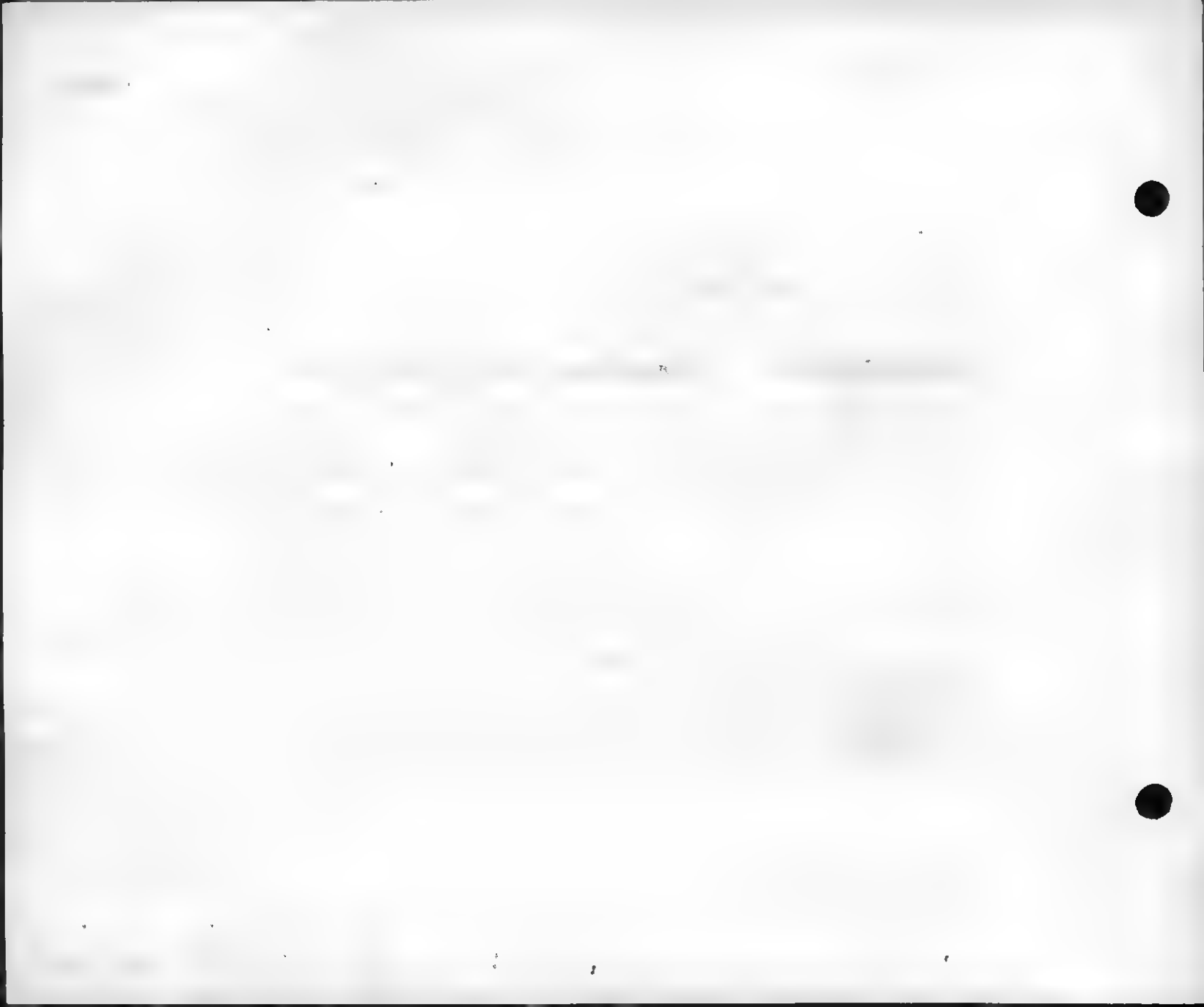
1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13526

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 c. LENGTH OF STAY IN 1b 4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3844 The Alameda e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY H. LAZZELL First Middle Last		4. DATE OF DEATH October 20, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1908 9. AGE (in years last birthday) 59 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State or foreign country) Baltimore, Md.
12. CIT ZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Piraino	
14. MOTHER'S MAIDEN NAME Josephine Imbroglio		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Charles B. Lazzell Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of right breast with massive metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from Oct. 9, 1967 , to Oct. 20, 1967 , that the (we) last saw the deceased alive on Oct. 20, 1967 , and that death occurred at 7:15 PM , from causes and on the date stated above			
22a. SIGNATURE Lawrence F. Misanik, M. D.		22b. DATE SIGNED 10/21/1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M. D.		22d. ADDRESS 7620 York Road, Towson 4, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/25/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR OCT 23 1967	
ADDRESS 4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Thomas J. Judge	



13521

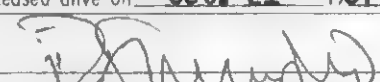
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

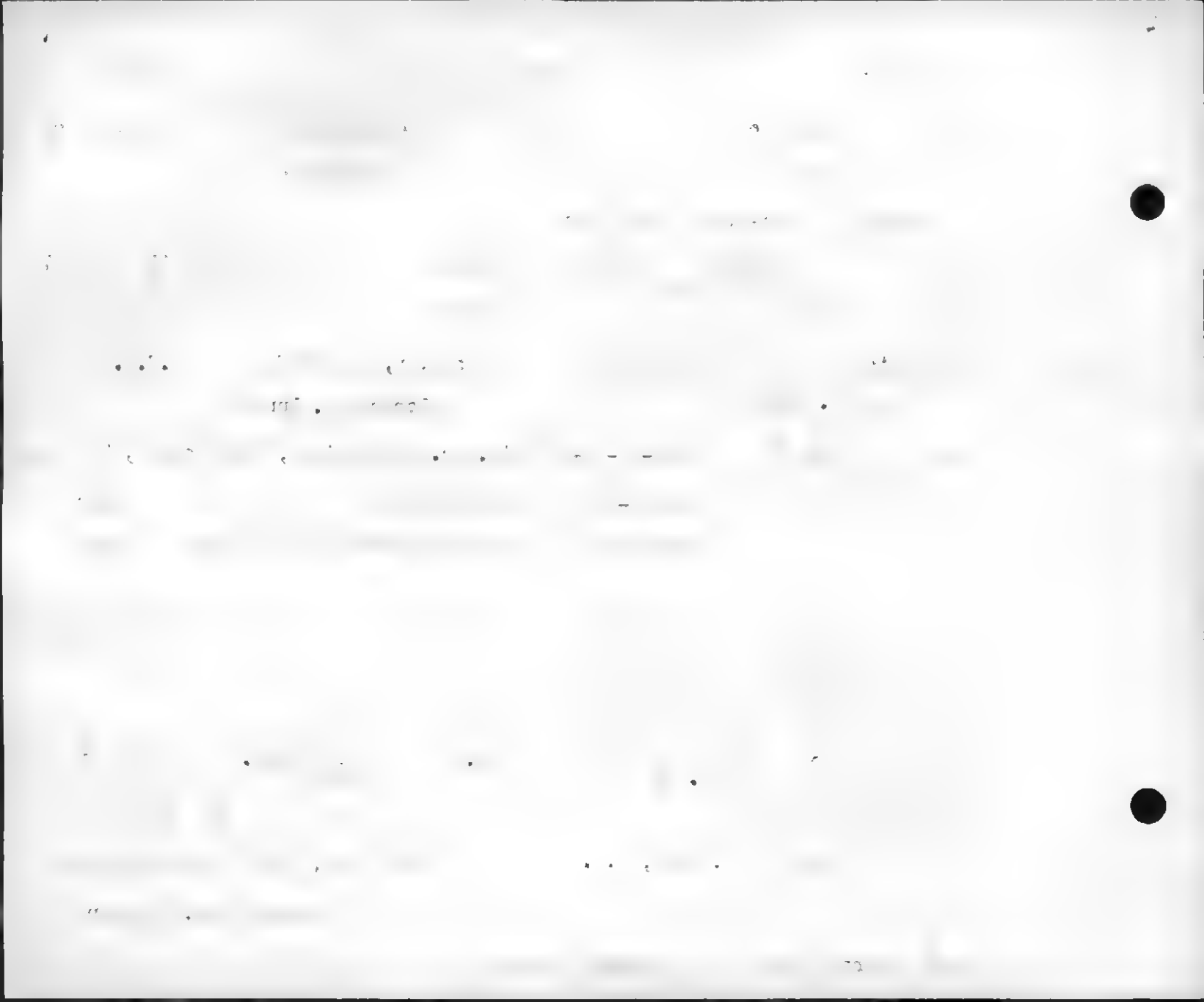
CERTIFICATE OF DEATH

13527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 71 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Grasonville	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle EZEKIEL Last LEGG		4 DATE OF DEATH Month OCTOBER Day 21 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/29
9 AGE (In years last birthday) 38		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Construction
11 BIRTHPLACE (County & State, or foreign country) Chester, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar M. Legg		14. MOTHER'S MAIDEN NAME Florence F. Hunter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes PL28		16 SOCIAL SECURITY NO. 214-28-35-08	
17 INFORMANT Clin. Rec. VA Hospital, Fort Howard, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF TESTES WITH GENERAL METASTASIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH HOURS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." "p.m." 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 11 , 19 67 , to Oct. 21 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 21 , 19 67 , and that death occurred at 8:30 PM from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 10/22/67	
22c. PHYSICIAN'S NAME (Type) RODOLFO G. MIRO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 24	23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE	23d. LOCATION (City or Town) (County) (State) Stevensville, Maryland
24 FUNERAL DIRECTOR Edgar L. Lane		25a. REC'D BY REGISTRAR OCT 24 1967	
25b. REGISTRAR'S SIGNATURE Lane Funeral Home		25c. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13522

13528

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. LENGTH OF STAY IN 1b .			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>				d. STREET ADDRESS <u>1118 Reisterstown Rd</u>			
3 NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Albert</u> Last <u>Lehmann</u>				4 DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 8, 1886</u>	9 AGE (in years last birthday) <u>81</u> Yrs	IF UNDER 1 YEAR Months Days Hours M.n.	IF UNDER 24 HRS Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Baltimore Transit - Street Cars</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13 FATHER'S NAME <u>Anthony A. Lehmann</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Vick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>Stone</u>				16 SOCIAL SECURITY NO <u>213 05-5144</u>			
17. INFORMANT <u>Mr. Arthur Lehmann, 26 Appleton Rd, Timonium, Md.</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>177X Carcinoma - prostate c metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>177X</u> DUE TO (c) <u>177X</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1967, to <u>October 7</u> , 1967, that (I) (we) lost saw the deceased alive on <u>October 10</u> , 1967, and that death occurred at <u>7:45 P</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>Clarence E. McWilliam</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <u>10-7-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Clarence E. McWilliam</u>				22d ADDRESS <u>11904 Reisterstown Rd Reisterstown Md</u>			
23a BURIAL (CREMATION REMOVAL) (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)				
<u>Buried</u>	<u>Oct. 10, 1967</u>	<u>St. Thomas Cemetery</u>	<u>Garrison, Baltimore, Md.</u>				
24. FUNERAL DIRECTOR <u>Frank H. Henkel, Pikeville, Md.</u>	25a REC'D BY REG-STRAR <u>Charles Judge</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	DATE <u>OCT 13 1967</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

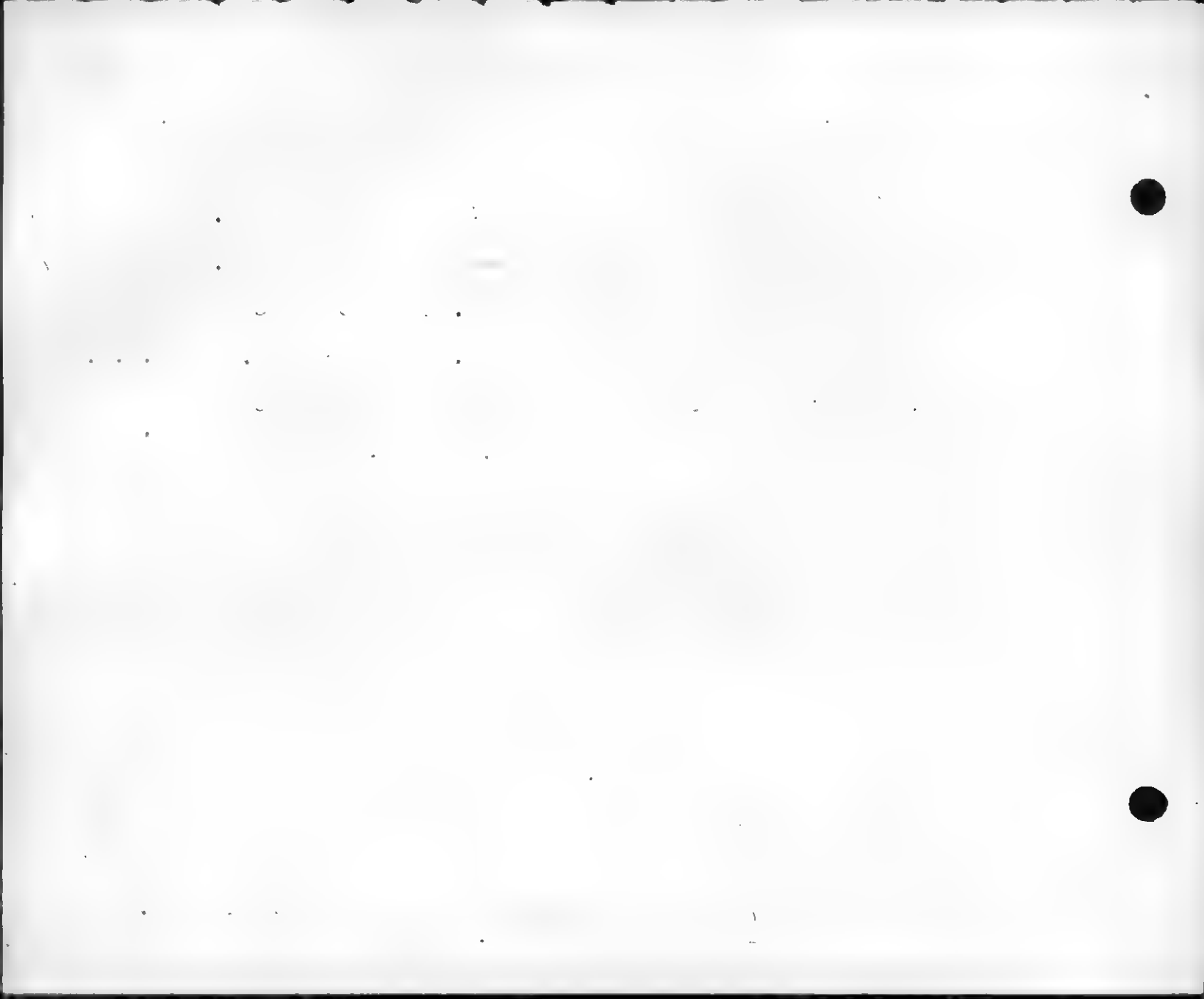
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 416 Shady Nook Ave												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 416 Shady Nook Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) Lizzie				First May				Middle Lenox				Last				4. DATE OF DEATH Month Oct. Day 4 Year 1967																			
5. SEX Female				6. COLOR OR RACE white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Feb. 14 1886				9. AGE (In years last birthday) 81 86 yrs.				10. IF UNDER 1 YEAR Months 7 Days 20				11. IF UNDER 24 HRS. Hours Min. 											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife								10b. KIND OF BUSINESS OR INDUSTRY 								11. BIRTHPLACE (County & State, or foreign country) St. Petersburg Va.								12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John Marshall Fowell												14. MOTHER'S MAIDEN NAME Mary E. Utterback																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)												16. SOCIAL SECURITY NO. None												17. INFORMANT Mrs. Mary C. Derrickson Address 416 Shady Nook Ave.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Hypertensive Interstitial Cardiac Vascular Dis. DUE TO (c) Diabetes Mellitus CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.																								INTERVAL BETWEEN ONSET AND DEATH 1 da.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from 1-11-1945 to 10-4-1967 , that (I) (we) last saw the deceased alive on 10-1-1967 , and that death occurred at 1 P. M, from the causes and on the date stated above.																																			
22a. SIGNATURE Wilmer K. Gallagher												22b. DATE SIGNED 10-5-67																							
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher												22d. ADDRESS 6209 Frederick Ave. Balt 12228, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial												23b. DATE THEREOF 10/7/1967				23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery								23d. LOCATION (City, town or county) (State) Balto Md.											
24. FUNERAL DIRECTOR Farley Cavanaugh -6601 Frederick Ave.												25a. REC'D BY REGISTRAR OCT 6 1967												25b. REGISTRAR'S SIGNATURE Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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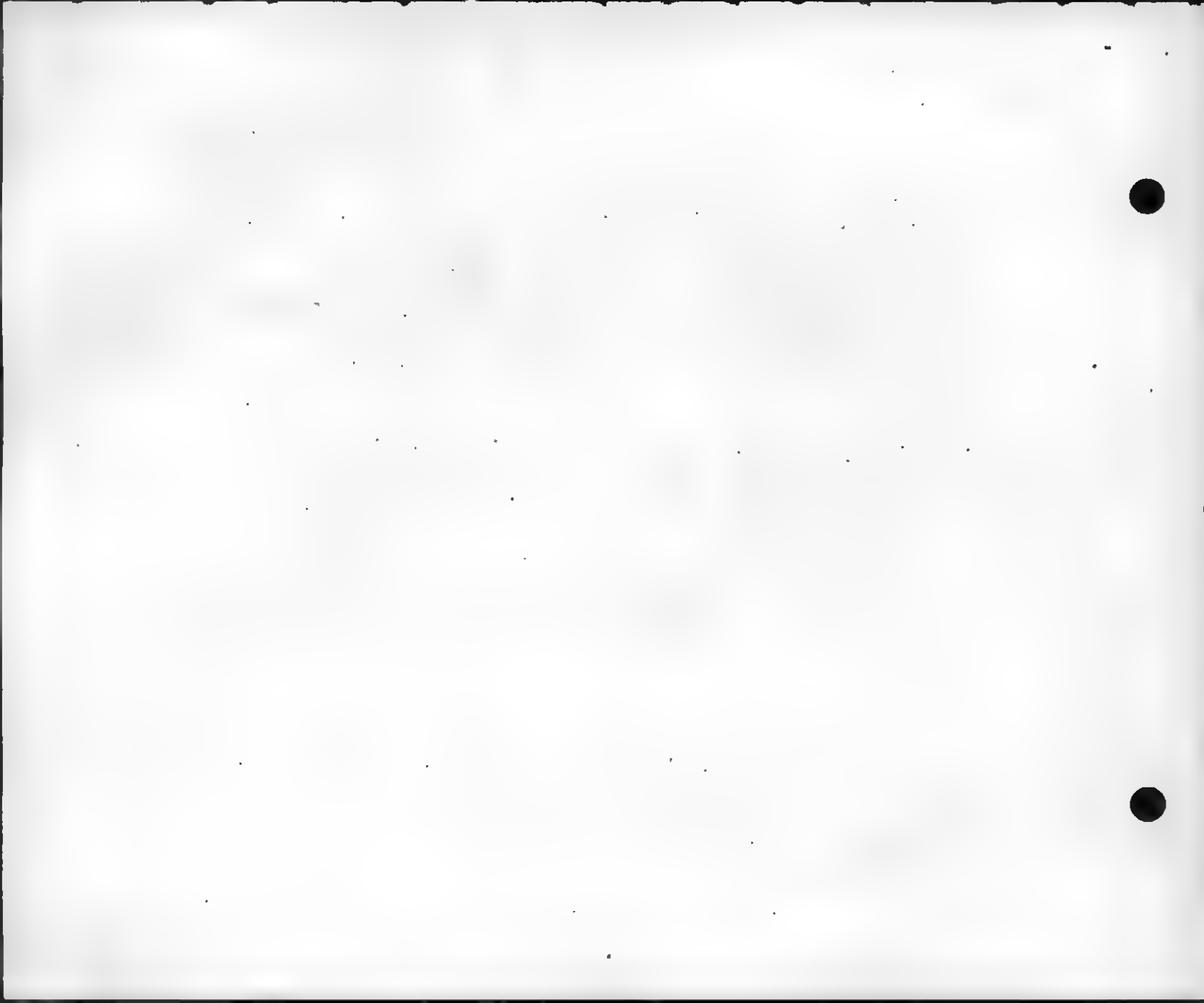
VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12524

13530

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Bertram Levi</u>		4. DATE OF DEATH Month Day Year <u>10 5 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-14</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Controller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baer Paper Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Levi</u>		14. MOTHER'S MAIDEN NAME <u>Meyer, JULIETTE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>XXXXXX W, W, 11 ARMY</u>		16. SOCIAL SECURITY NO. <u>218-10-8025</u>	
17. INFORMANT <u>MRS. AUDREY T. LEVI</u>		Address <u>2212 ARDEN ROAD #9</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO <u>Lymphoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8 - 6</u> , 19 <u>67</u> to <u>10 - 5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10 - 5</u> , 19 <u>67</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>10/5/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>10-8-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		23d. LOCATION (city, town or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u>		25a. REC'D BY REGISTRAR <u>OCT 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

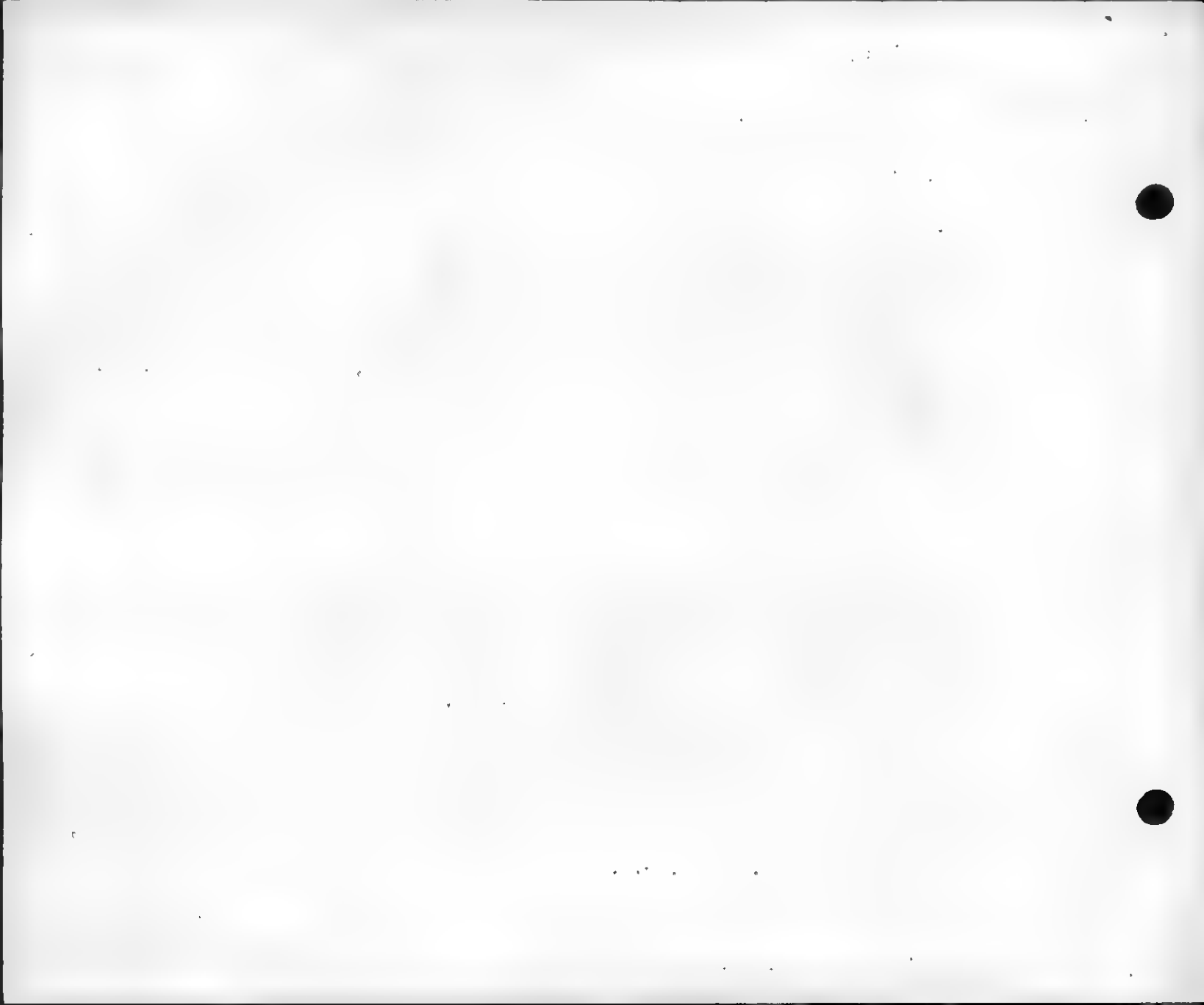
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

23525

CERTIFICATE OF DEATH

13531

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write R. R. and give nearest town) Baltimore		c. LENGTH OF STAY IN lb Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 5506 Minnoka Ave. #21215	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Frank Levin		4 DATE OF DEATH Month Day Year 10 15 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/9/ 1906
9 AGE (In years last birthday) 61 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT		10b. KIND OF BUSINESS OR INDUSTRY Calvert Distillery Baltimore, Maryland	
11 BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME ISAAC LEVIN		14. MOTHER'S MAIDEN NAME ANNA ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 217-22-4338	
17 INFORMANT MRS. DORA LEVIN, 5506 MINNOKA AVENUE #21215		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction L. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 10/15 , 19 67 , to 10/15 , 19 67 , that (I) (we) last saw the deceased alive on 10/15 , 19 67 , and that death occurred at 9:45 M, from causes and on the date stated above			
22a. SIGNATURE Ramon P. Lopez		22b. DATE SIGNED October 15, 1967	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M.D.		22d. ADDRESS 7620 York Road Towson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-17-67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24 FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR DATE OCT 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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13526

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13532

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT NURSING HOME		d. STREET ADDRESS 6625 FREDERICK AVE	
3. NAME OF DECEASED (Type or print) LAWRENCE F. LITZENBERGER		4. DATE OF DEATH Month OCT. Day 22 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 6, 1898
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 1 Days 16 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10b. KIND OF BUSINESS OR INDUSTRY TAVERN	
11. BIRTHPLACE (County & State, or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LAWRENCE LITZENBERGER		14. MOTHER'S MAIDEN NAME CATHERINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-01-5810	
17. INFORMANT Mr. Lawrence Litzenberger		Address Cheltenham - 6625 Frederick Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis of the brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis CVD. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis CVD.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 to Oct 22, 1967 , that (I) (we) last saw the deceased alive on Oct 21, 1967 , and that death occurred at 12 M, from causes and on the date stated above.			
22a. SIGNATURE J. C. Pound		22b. DATE SIGNED 10/23/67	
22c. PHYSICIAN'S NAME (Type) J. C. Pound		22d. ADDRESS 3325 Frederick Ave	
23a. BURIAL, CREMATION, or other disposal (Specify) Removal	23b. DATE THEREOF 10-23-67	23c. NAME OF CEMETERY OR CREMATORY QUAKERTOWN UNION CEM	23d. LOCATION (City or Town) (County) (State) QUAKERTOWN - PENN.
24. FUNERAL DIRECTOR Volley - Cranney & H. Catonsville Md.		25a. REC'D BY REGISTRAR DATE OCT 25 1967	
		25b. REGISTRAR'S SIGNATURE William J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

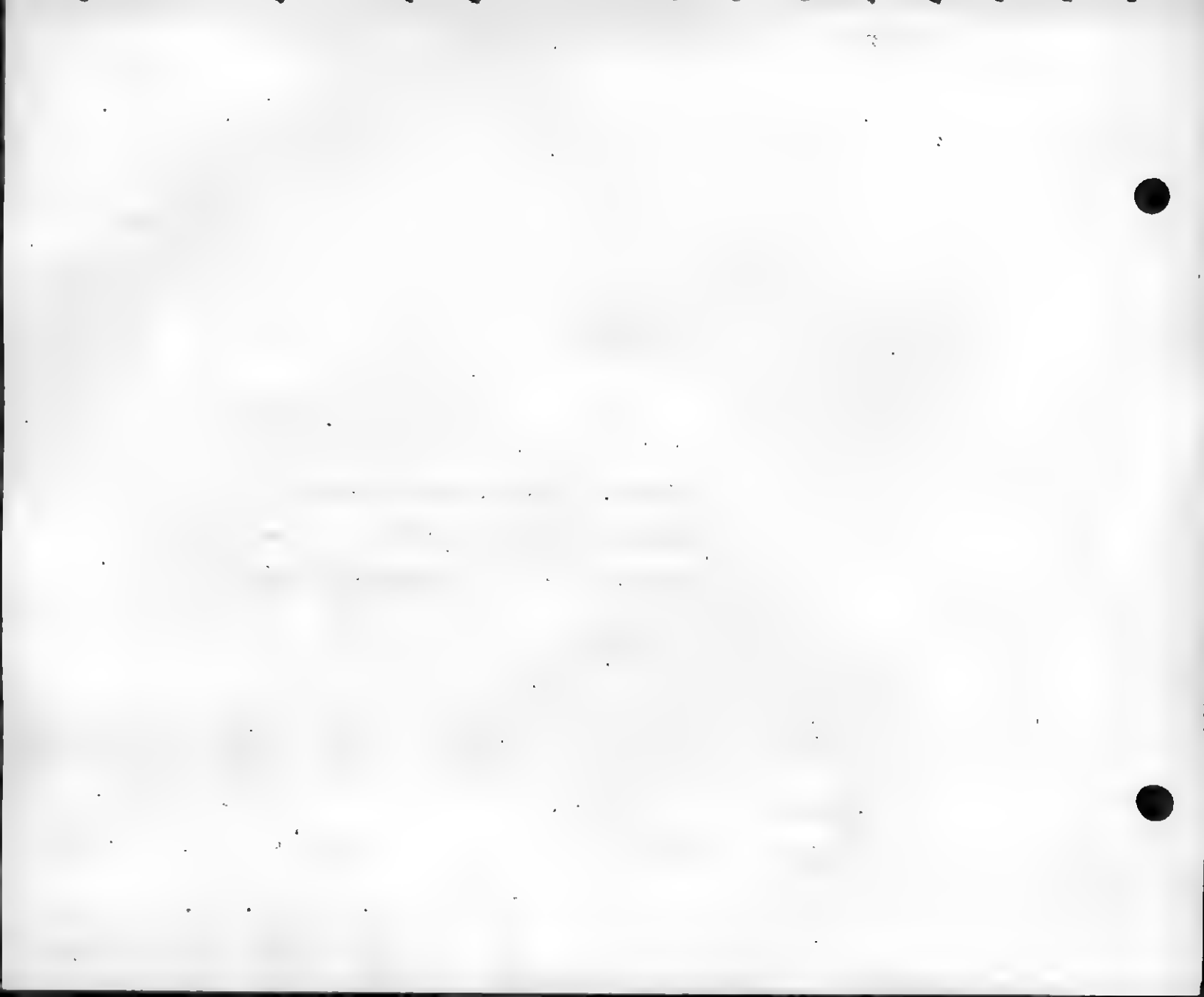


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13533											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>26 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21206</u> d. STREET ADDRESS <u>1324 Rosewick Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>LOEFFLER</u>						4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-99</u>		9. AGE (in years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heat Packer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Loeffler</u>						14. MOTHER'S MAIDEN NAME <u>Eliabeth Peterson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>21B-03-9216</u>		17. INFORMANT <u>Catherine Loeffler, wife Same as Margaret Berger - Daughter - above</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO VASCULAR COLLAPSE</u> <u>199.2</u> DUE TO <u>Hemorrhage great vessels of neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arterial Carcinoma pharyngo-esophagus</u> DUE TO <u>Arterial Carcinoma pharyngo-esophagus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>prolonged & slow</u> <u>~ 1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> to <u>Oct 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 22</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>David F. Fairbanks</u>						22b. DATE SIGNED <u>Oct 22, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>DAVID F. FAIRBANKS</u>						22d. ADDRESS <u>G.B.M.C. 6701 No Charles Balto. Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u> <u>3331 Brehms Lane #13</u>						25a. REC'D BY REGISTRAR <u>OCT 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

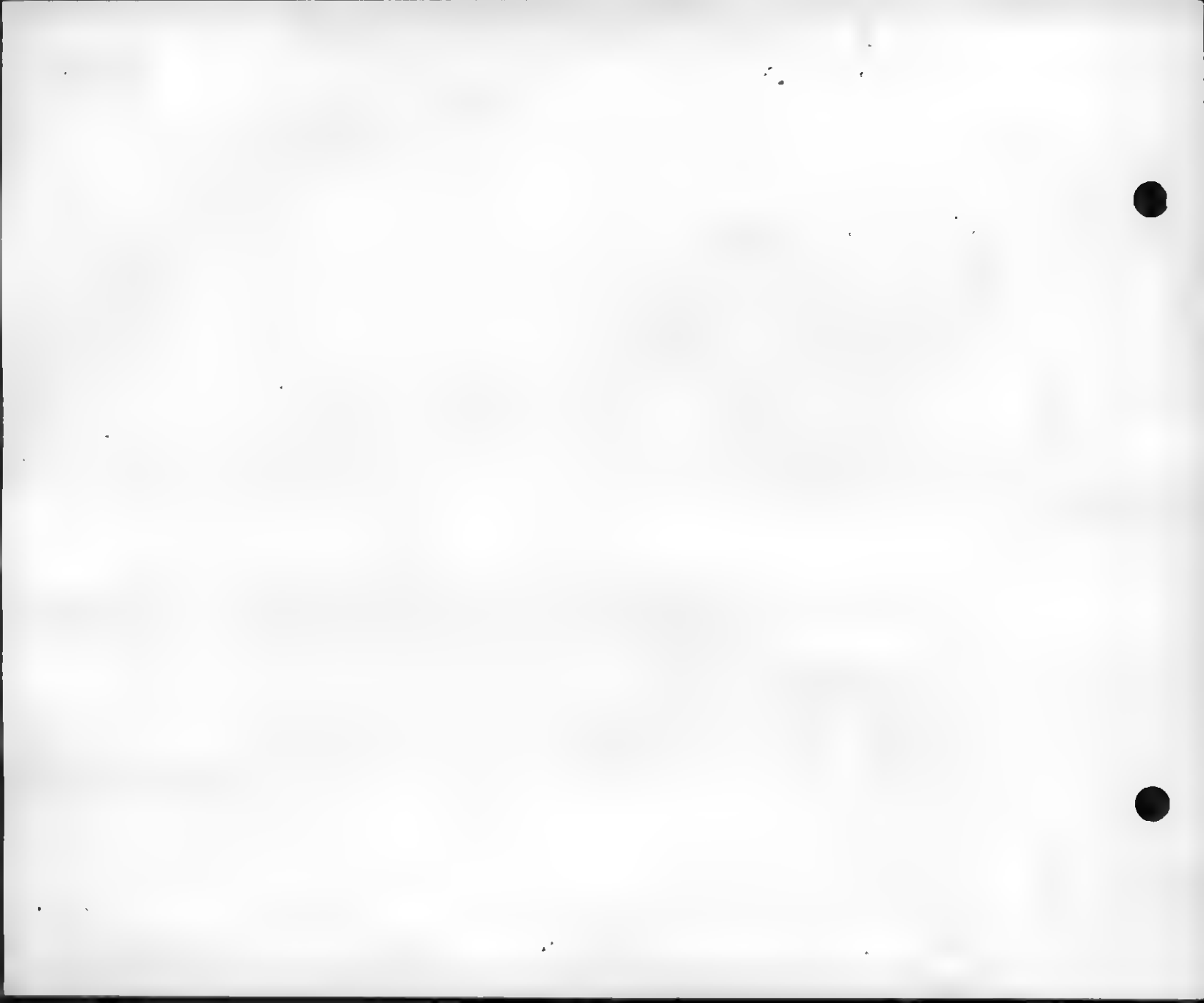
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15021

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>4 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Villa Maria - Notch Cliff</u>				d. STREET ADDRESS <u>Glen - Arm</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sister Mary Rufina Loesch</u> First Middle Last				4. DATE OF DEATH <u>10 / 31 / 1967</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/1873</u>		9. AGE (In years last birthday) <u>94</u> yrs	10. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONVENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONVENT</u>		11. BIRTHPLACE (County & State or foreign country) <u>ERIE, PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Loesch</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Anthony</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-54-3324 J</u>		17. INFORMANT <u>Se. Catherine Mary - Glen Arm 21057</u> Address <u>NOTCH CLIFF</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Generalized atherosclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 7</u> , 19 <u>66</u> , to <u>10/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>September 7, 1967</u> , and that death occurred at <u>12 noon</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Henry Brinkley</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Raymond J. Curran</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sisters Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Arm Balt. Md.</u>	
24. FUNERAL DIRECTOR <u>Raymond J. Curran</u>				25a. REC'D BY REGISTRAR <u>Nov 8 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

13534

10528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY _____ ✓	
b. CITY OR TOWN (If outside corporate limits, write nearest town) Baltimore		c. LENGTH OF STAY IN 7b _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summitt Nursing Home		e. STREET ADDRESS 1704 Cole St.	
3. NAME OF DECEASED (Type or print) Hattie E. Luh		4. DATE OF DEATH Month October Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10 1888
9. AGE in years 78 (Type or print) yrs		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Schoenberger		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. Norbert Wheeler		Address 519 Cleveland Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Chronic disease of the pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2 miast. of the liver (b) DUE TO _____ (c) DUE TO _____			INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1958 to 10.7.1967 that (I) (we) last saw the deceased alive on 10.6.1967 and that death occurred at 100M , from causes and on the date stated above.			
22a. SIGNATURE John W. Wilkins		22b. DATE SIGNED 10.9.67	
22c. PHYSICIAN'S NAME (Type) J. K. WILKINS		22d. ADDRESS 215 Wilkins Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/10/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Balto. Maryland
24. FUNERAL DIRECTOR Witzke & Sons 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13533

13535

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8711 Summit 34		d. STREET ADDRESS 8711 Summit 34	
3. NAME OF DECEASED (Type or print) First CLAIRE Middle DANALEE Last LYNCH		4. DATE OF DEATH Month October Day 20 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/17
9. AGE (in years last birthday) yrs 49		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley A. Thornburg		14. MOTHER'S MAIDEN NAME Cora Silfies	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no		16. SOCIAL SECURITY NO 154-12-2431	
17. INFORMANT Mr. Leslie W. Lynch		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED October 20, 1967	
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) Baltimore		23b. DATE THEREOF 10/23/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Park Cem.		23d. LOCATION (City or town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25a. REC'D BY REGISTRAR OCT 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THIS CERTIFICATE IS TO BE FILLED IN BY THE FUNERAL DIRECTOR

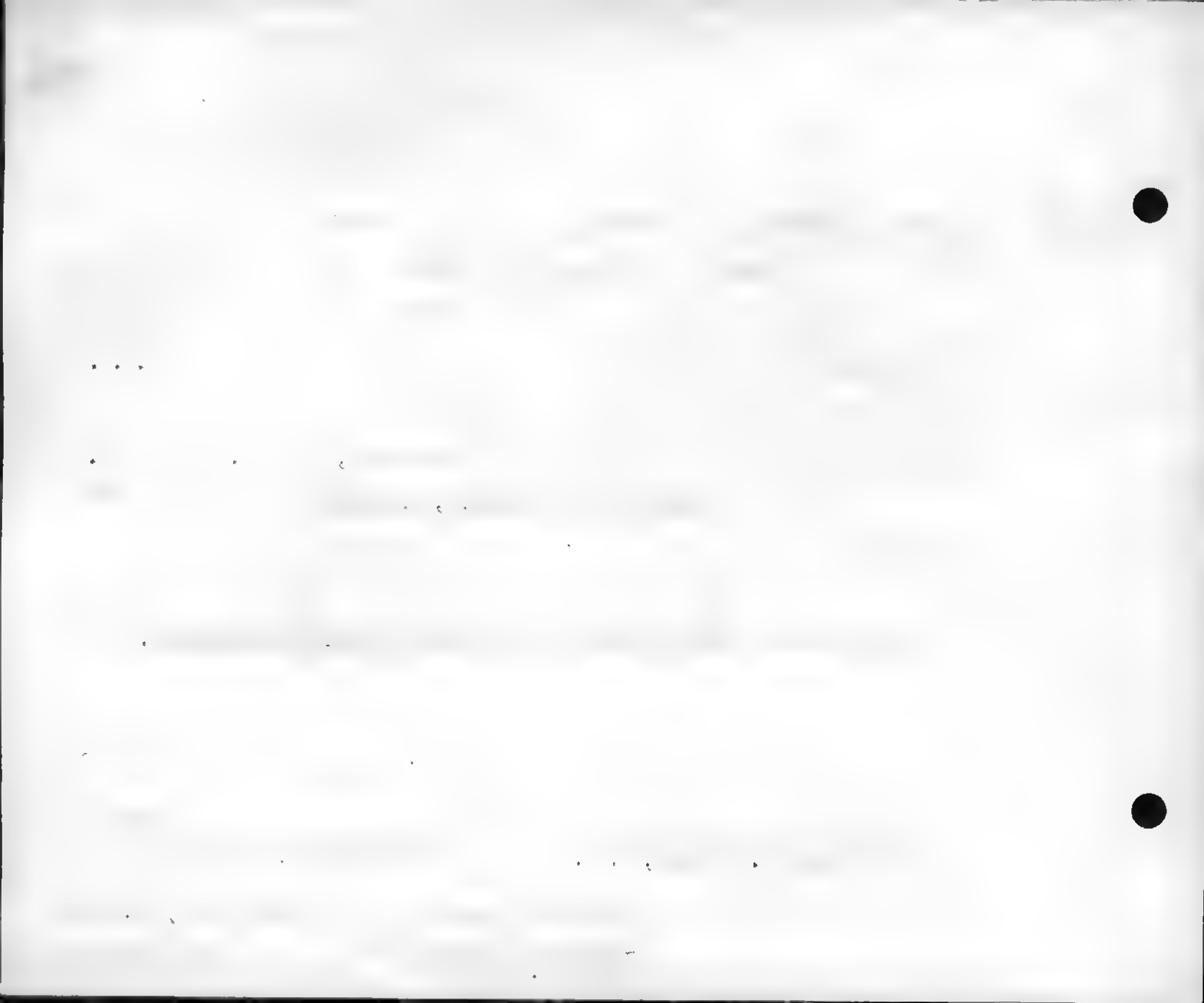
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13531

13536

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in lb 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS ROUTE #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last LAWRENCE ASBERRY LYONS				4. DATE OF DEATH Month Day Year OCTOBER 9, 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/27/11	9 AGE (In years last birthday) yrs. 56	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saw operator		10b. KIND OF BUSINESS OR INDUSTRY LUMBAR		11 BIRTHPLACE (County & State, or foreign country) NEWBURN, VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM LYONS				14 MOTHER'S MAIDEN NAME VIOLA WEBB			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16 SOCIAL SECURITY NO 412 09 84 16		17 INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGIC PNEUMONIA, BILATERAL TIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH RECENT
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE WITH HYPERTENSIVE CARDIOVASCULAR DIS.							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xxx (this hospital) attended the deceased from OCT 7, 1967 to OCT 9, 1967 , that no (we) last saw the deceased alive on OCT 9, 1967 , and that death occurred at 4:45 AM , from causes and on the date stated above.							
22a SIGNATURE John D. Talbert				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d ADDRESS VAH FORT HOWARD, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 12, 1967		23c NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY		23d LOCATION (City or Town) (County) (State) CARROLL COUNTY, MARYLAND	
24. FUNERAL DIRECTOR TIPTON ELINE FUNERAL HOME				25a. REC'D BY REGISTRAR DATE OCT 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

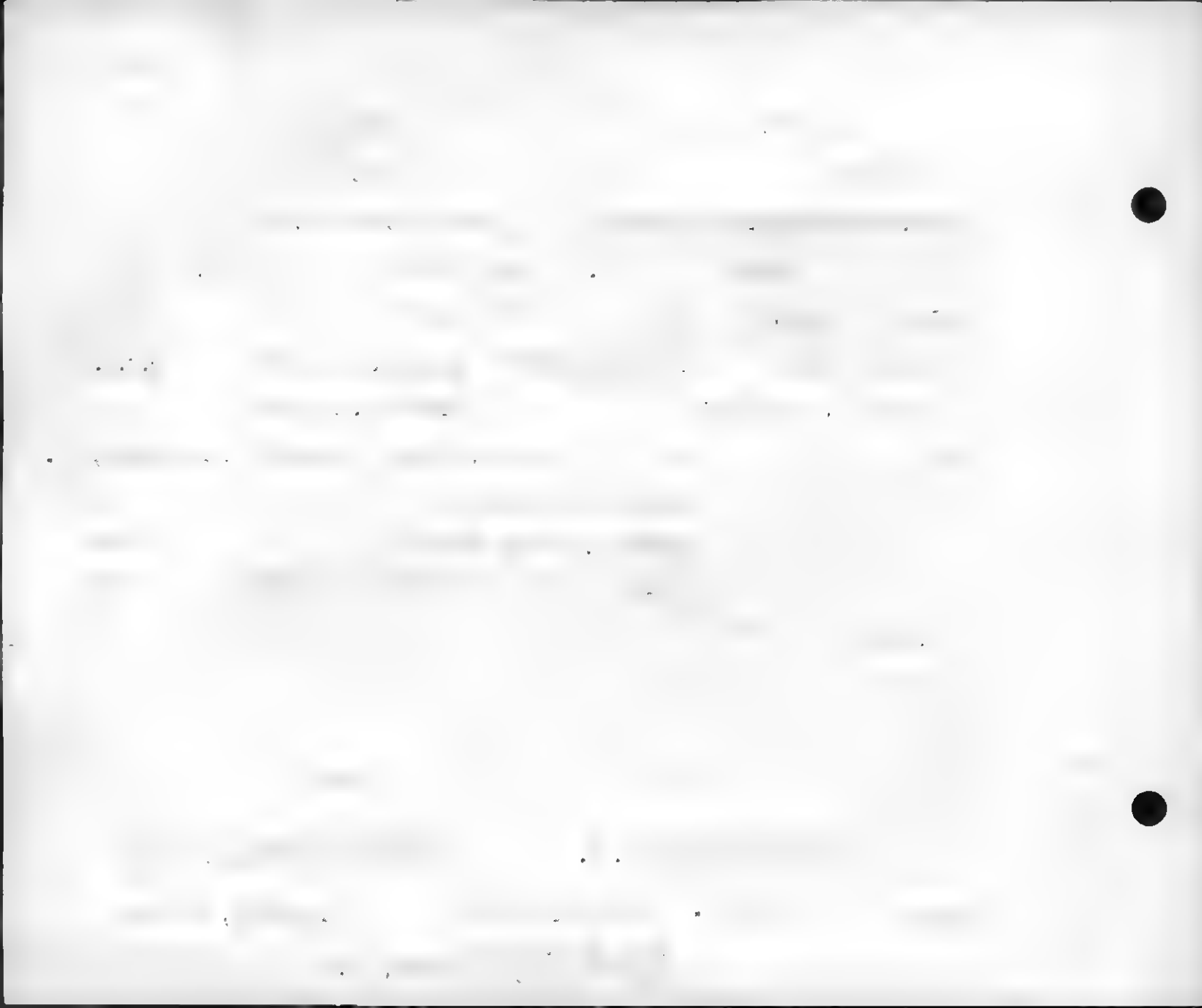
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13537

1. PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 606 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY MARYLAND		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d STREET ADDRESS 5601 BIRCHWOOD AVENUE		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOHN Middle R. Last MAC CUBBIN		4 DATE DEATH OCTOBER 6 19 67		5 SEX MALE 6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		9 AGE (In years last birthday) 80 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		10b KIND OF BUSINESS OR INDUSTRY INSURANCE COMPANY	
11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME WILLIAM F. MAC CUBBIN		14 MOTHER'S MAIDEN NAME FRANCES E. STAYLOR	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO. 214 03 11 45		17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO (b) CEREBRAL VASCULAR DISEASE DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 2/6/66 , 19__, to 10/6/67 , 19__, that (we) last saw the deceased alive on 10/6/67 , 19__, and that death occurred on 6:00AM , from causes and on the date stated above.							
22a SIGNATURE Chong Choon Han M.D.				22b DATE SIGNED 10/6/67		22c PHYSICIAN'S NAME (Type) CHONG CHOON HAN, M. D.	
22d ADDRESS VAH FORT HOWARD, MARYLAND				22e RES. BY REGISTRAR OCT 9 1967			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 10/10/67.		23c NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR RUCK FUNERAL HOME				25a REGISTRAR'S SIGNATURE Charles Judge			
25b ADDRESS HARFORD ROAD, BALTIMORE, MD.				25c DATE OCT 9 1967			



13538

FOR STATE
HEALTH DEPT

13533

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital (DOA)		d. STREET ADDRESS 27 Dublin Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ARTHUR R. MACHESNEY		4 DATE OF DEATH Month October Day 6 Year 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 24, 1904
9 AGE (In years last birthday) 63		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Design Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 167-05-2011	
17. INFORMANT Family information		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Blunt impact to head with head and neck injuries			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blunt impact to head with head and neck injuries			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell down stairs in front of factory	
20c. TIME OF INJURY Month, Day, Year 4:15 p.m. 10 6 19 67		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Factory		20f. (City or town) (County) (State) Middle River Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED 10-7-67	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery	23d. LOCATION (City or town) (County) (State) Winkton, Maryland
24. FUNERAL DIRECTOR John Wynn's Sons, Towson, Maryland		25a. DEPUTY REGISTRAR'S SIGNATURE Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE OCT 16 1967	



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #12 Film #G393 10/13/67 ph

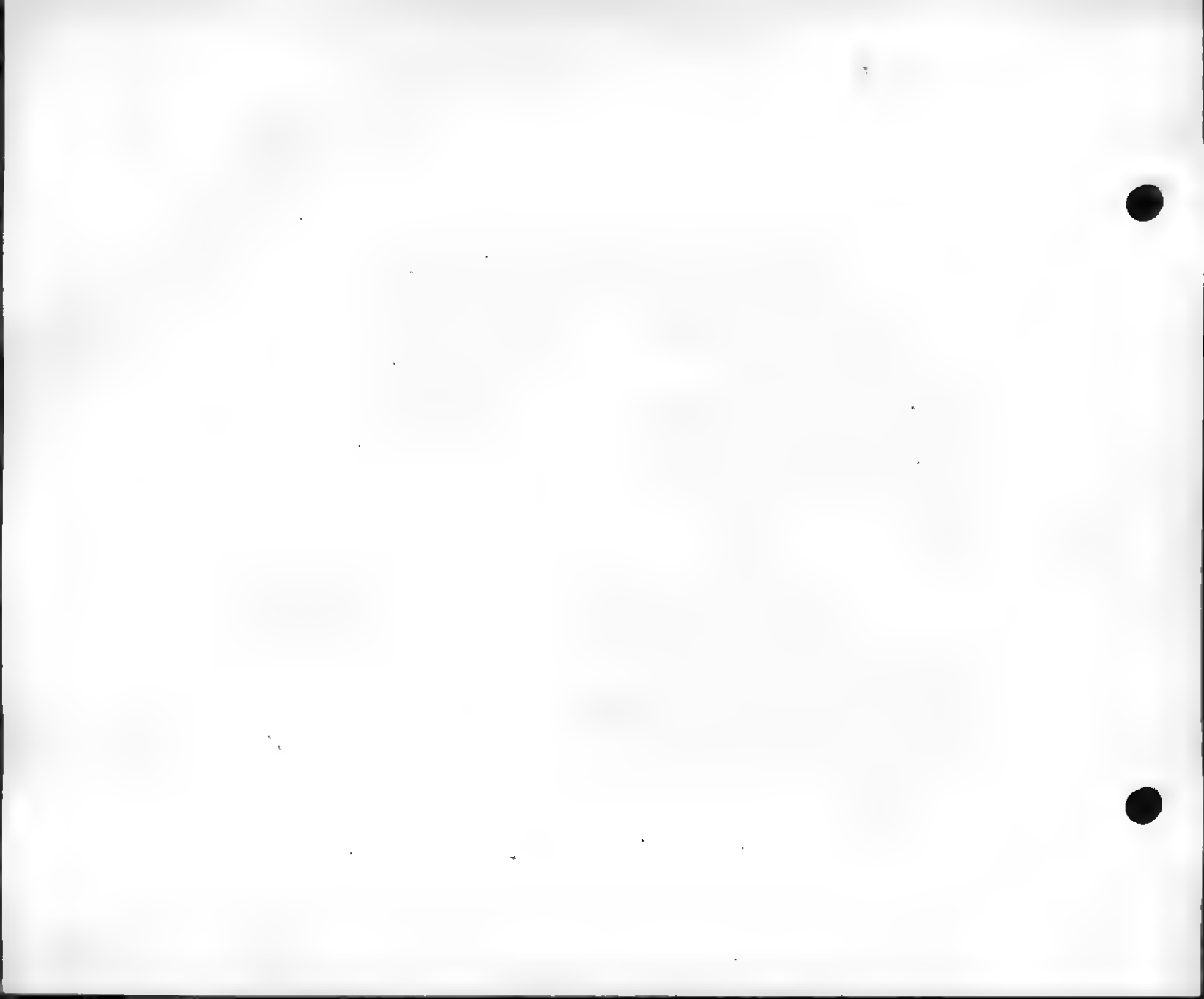
135334

CERTIFICATE OF DEATH

135339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN It TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor		d. STREET ADDRESS 2706 Joppa Rd	
3. NAME OF DECEASED (Type or print) First Joseph Middle Maggio Last Maggio		4. DATE OF DEATH Month OCT Day 4 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28. OCT 1880
9. AGE (in years last birthday) 86 yrs		10. UNDER 1 YEAR Months 8 Days 6 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY RET.	
11. BIRTHPLACE (County & State, or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SALVATORE MAGGIO		14. MOTHER'S MAIDEN NAME GIOVANINA VINZZINA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO —	
17. INFORMANT SAMUEL MAC		Address 556 S. Rolling Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1902 , 1962, to 400 , 1967, that (I) (we) last saw the deceased alive on 4 OCT 1967 , and that death occurred at 730 M , from causes and on the date stated above.			
22a. SIGNATURE William Goodman, M.D.		22b. DATE SIGNED 5 OCT 67	
22c. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN, M.D.		22d. ADDRESS 133 + 2nd Street - 21227	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-OCT-1967	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	23d. LOCATION (City or Town) (County) (State) BALTO. MD
24. FUNERAL DIRECTOR E. S. MacNabb		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 301 Frederick Rd Baltimore 21228 MD		DATE OCT 9 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

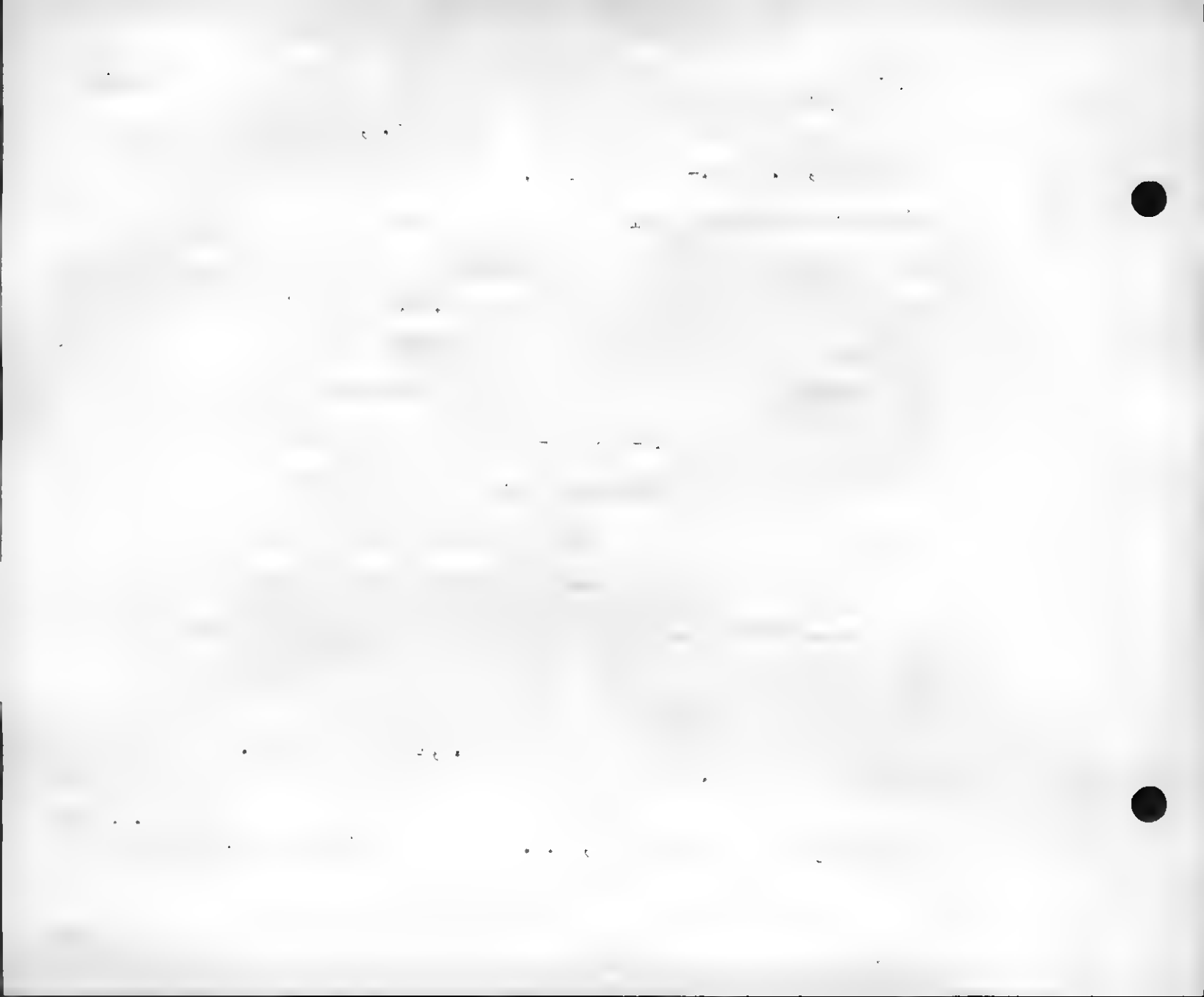
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE since Oct. 8, 1945 in this Hospital b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Md. 21228		c. LENGTH OF STAY IN TB since 1945.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS High Street	
3 NAME OF DECEASED (Type or print) Hazel		4. DATE OF DEATH Month October Day 8 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 26, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years birthday) yrs 73
11 BIRTHPLACE (County & State, or foreign country) Rockport Iowa		12 CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Samuel Stoneking		14. MOTHER'S MAIDEN NAME Florence Lowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-16-3655-T	
17. INFORMANT Spring Grove Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (about 5 days) DUE TO Arteriosclerotic Heart Disease (5 years +) DUE TO Generalized Arteriosclerosis (5 years +) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus and Central Nervous System Syphilis (20 yrs+)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from Oct. 8, 1945 , 19 67 , to Oct. 8 , 19 67 , that (x) (we) last saw the deceased alive on Oct. 8 (9AM) 19 67 , and that death occurred at 9:30AM , from causes and on the date stated above.			
22a. SIGNATURE <i>S. Jurekovich</i>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED Oct. 8, 1967
22c. PHYSICIAN'S NAME (Type) Imre Kopits, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY The Anatomy Board of Maryland	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <i>Novell Funeral Home, Pikesville - 894</i>		25a. RECEIVED BY REGISTRAR OCT 19 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Jurek</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

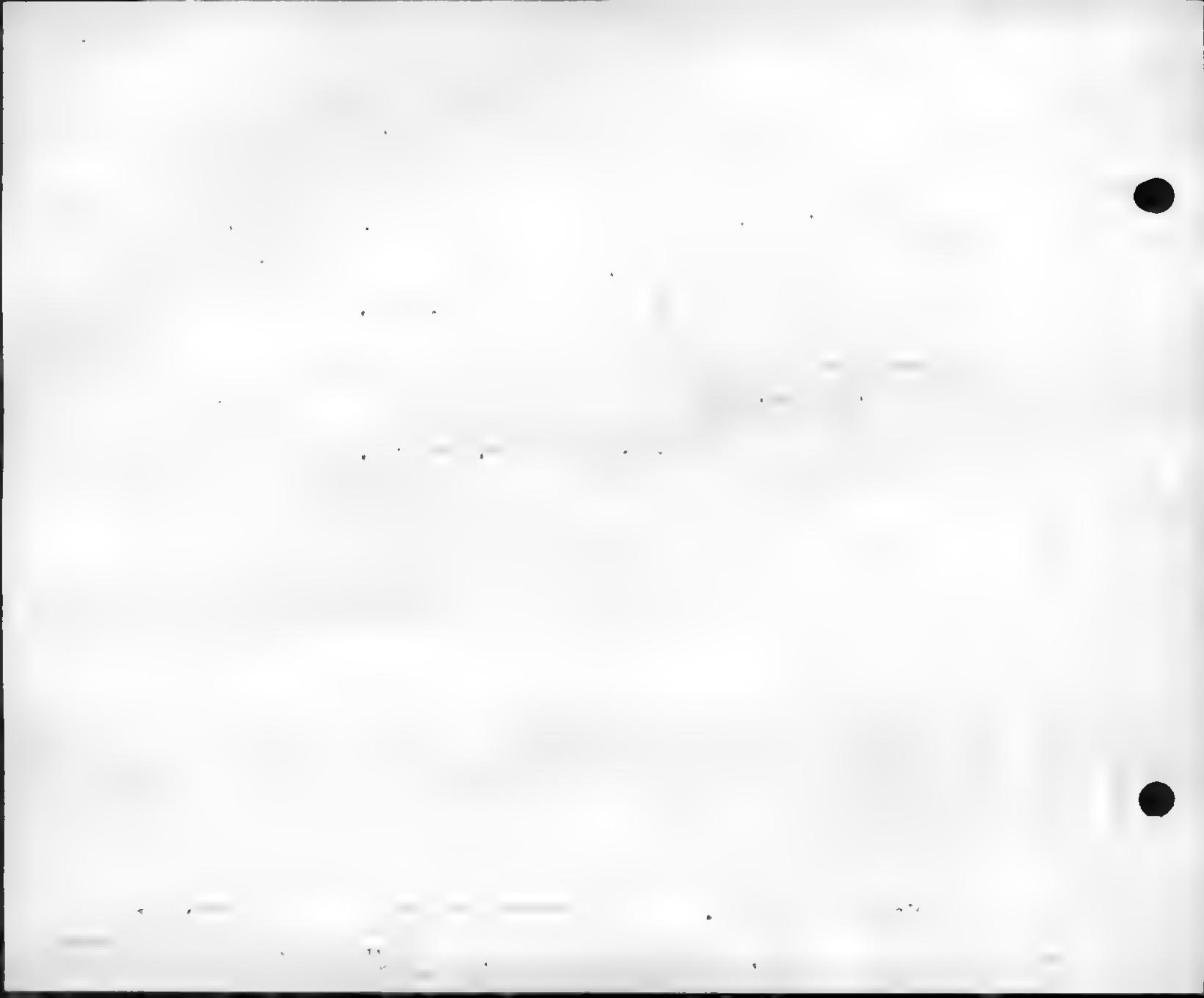
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13536

13541

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Armacost Nursing Home</u>		d. STREET ADDRESS <u>1522 Lakeside Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Regina J. Mardaga</u>		4 DATE OF DEATH Month Day Year <u>October 16, 1967</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 24, 1870.</u>
9. AGE (In years last birthday) yrs <u>97</u>		10. IF UNDER 1 YEAR Months Days Hours Mins. <u>_____</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Mardaga</u>		14. MOTHER'S MAIDEN NAME <u>Mary Grob</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-56-3286-J</u>	
17. INFORMANT <u>Mrs. Jessie M. Hoeck</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO (b) <u>_____</u> DUE TO (c) <u>_____</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 6, 1967</u> to <u>Oct. 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 12, 1967</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Loy M. Zimmerman</u> M.D.		22b. DATE SIGNED <u>10/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman M.D.</u>		22d. ADDRESS <u>3202 Hartford Rd., Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/19/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13537

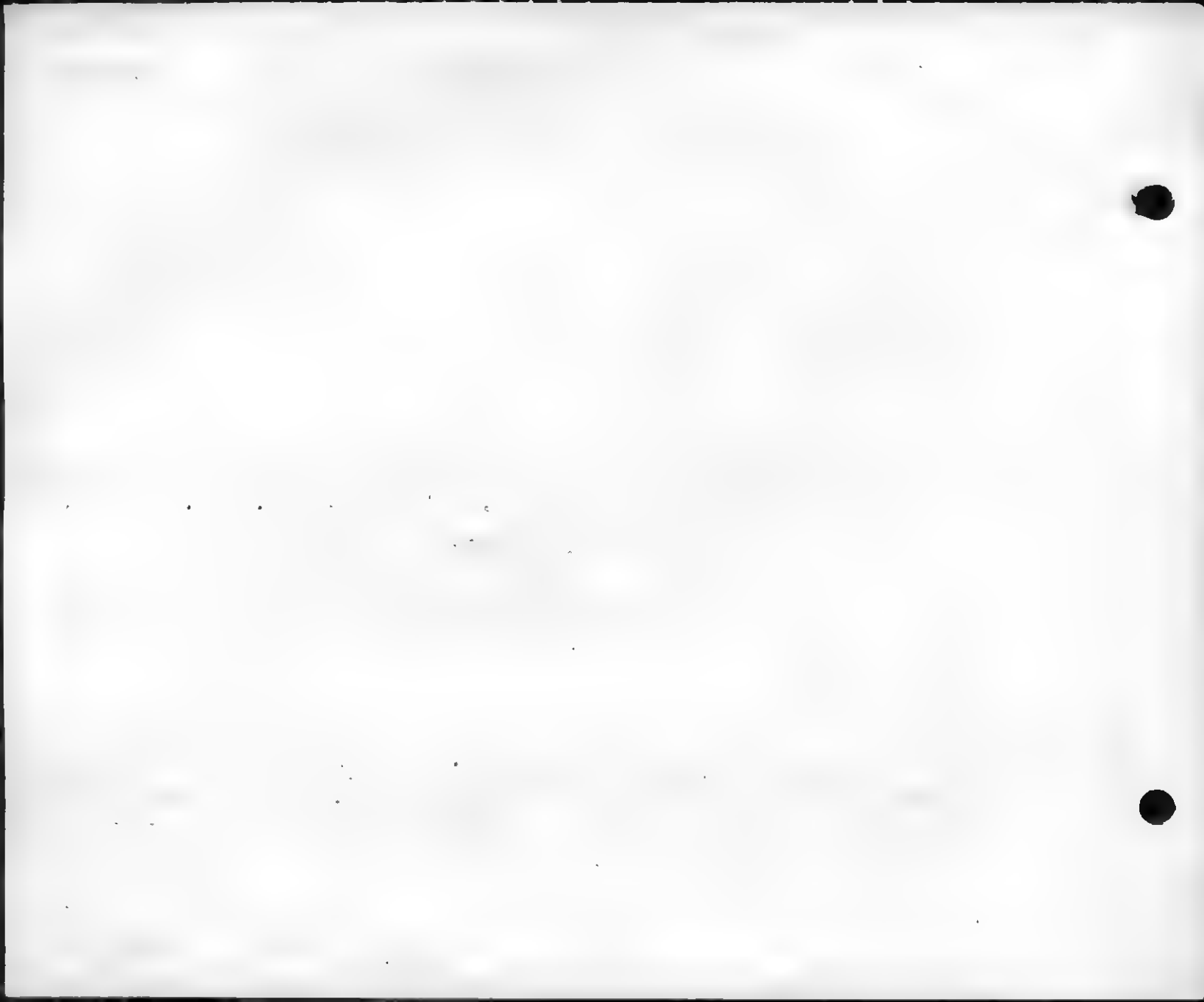
CERTIFICATE OF DEATH

13542

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY — ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9yr8mth8days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 808 West Lombard Street	
3. NAME OF DECEASED (Type or print) First Joseph Middle Matus Last Matus		4. DATE OF DEATH Month October Day 28 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898
9. AGE (In years last birthday) yrs 69		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Matus		14. MOTHER'S MAIDEN NAME Anile	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 212-22-8076	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, org. unk. DUE TO (b) Bronchitis, chronic DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Arteriosclerotic CVHD with atrial Fibrillation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Feb. 20 , 19 58 to Oct. 28 , 19 67 , that he (we) lost saw the deceased alive on Oct. 28 , 19 67 , and that death occurred at 6:40 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		22b. DATE SIGNED 10-20-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/3/67	23c. NAME OF CEMETERY OR CREMATORY OAKLAND CEM.	23d. LOCATION (City or Town) (County) (State) Phila. Phila. Pa.
24. FUNERAL DIRECTOR Norkas Funeral Home		25a. REC'D BY REGISTRAR NOV 3 1967	
25b. REGISTRAR'S SIGNATURE <i>John M. Matus</i>		25c. REGISTRAR'S SIGNATURE <i>John M. Matus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13538

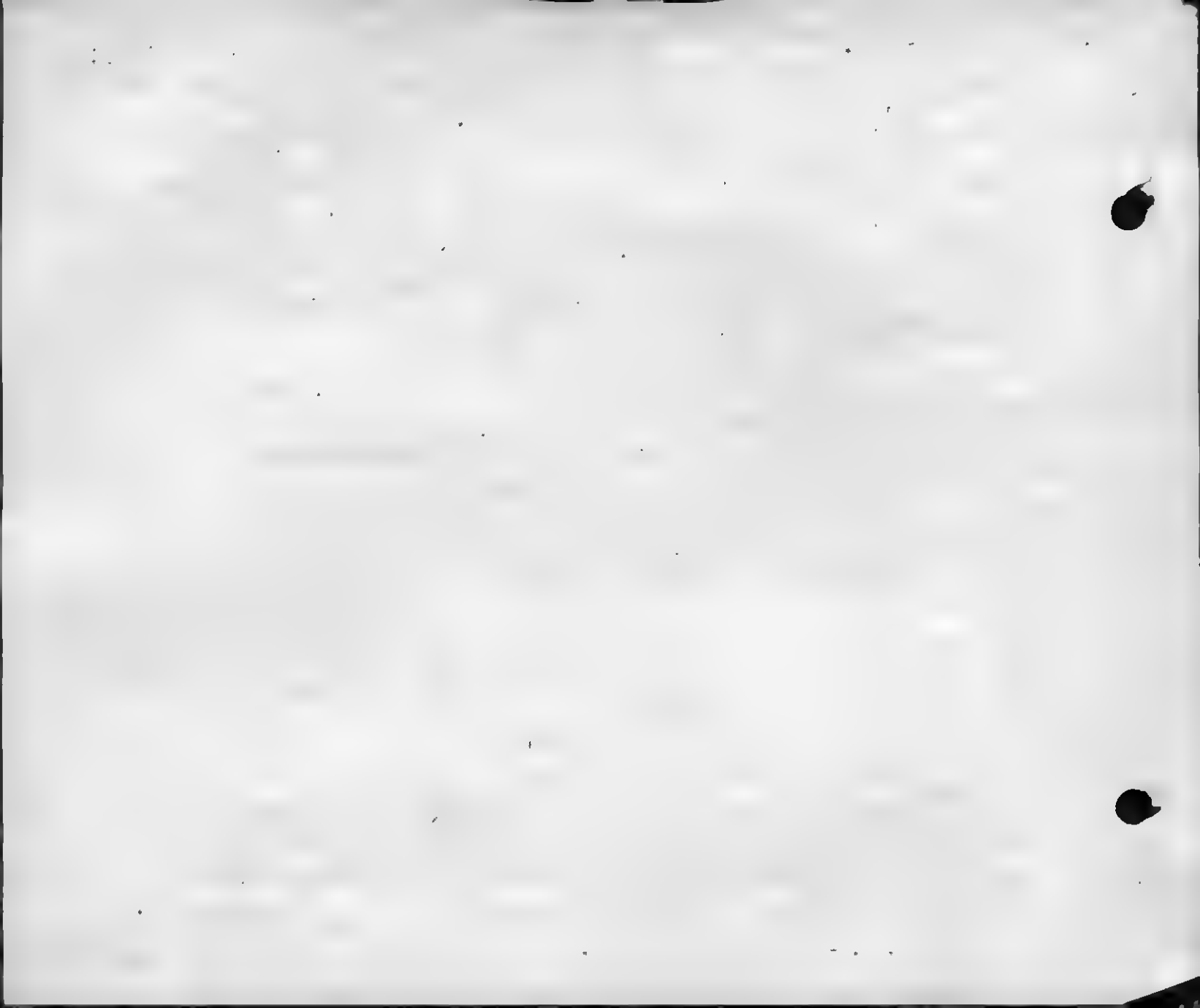
CERTIFICATE OF DEATH

13543

Items #2c & d Film 10/16/67 ph

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle L. Last MAUS		4. DATE OF DEATH Month Oct. Day 3 Year 1967	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 17, 1874
9. AGE (In years last birthday) 92 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Myers		14. MOTHER'S MAIDEN NAME Annie L. Lefeure	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Richard Gilbert 506 Equitable Building	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema and Pneumonia Conditions, if any, which gave rise to immediate cause (b) A.G.C.V.D. (a), stating the underlying cause last, (c)		INTERVAL BETWEEN ONSET AND DEATH Hrs. Hrs. 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 24, 1967 , to 10/3/1967 , that (I) (we) last saw the deceased alive on 10/3/1967 , and that death occurred at 1 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Witzke		22b. DATE SIGNED 10/3/1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/67	
23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D.		25a. REC'D BY REGISTRAR OCT 4 1967	
ADDRESS - 4101 Edmondson Ave.		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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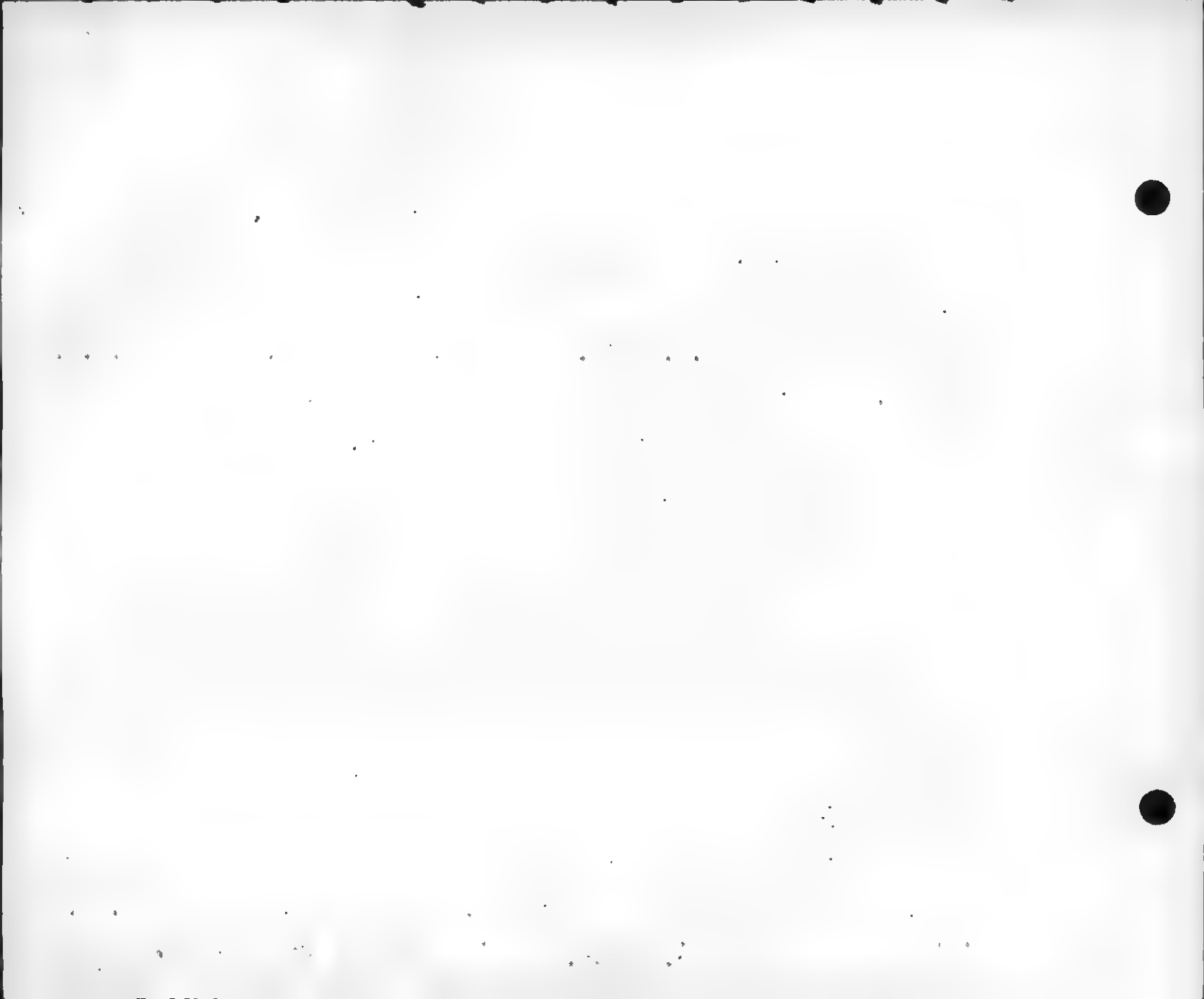
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13545

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		d. STREET ADDRESS 620 Harwood Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Dominic McEvoy		4. DATE OF DEATH Month Day Year 10 17 1967	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1907
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter J. McEvoy		14. MOTHER'S MAIDEN NAME Anna Krestel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-7488	
17. INFORMANT Mrs. Beatrice W. McEvoy		Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 165X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-14 , 19 67 , to 10-17 , 19 67 , that (I) (we) last saw the deceased alive on 10-17 , 19 67 , and that death occurred at 9:28 PM , from the causes and on the date stated above.			
22a. SIGNATURE John E. Adams		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22d. ADDRESS 6701 N. Charles Street, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/1967	
23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION (City, town or county) (State) Parkville, Balto. Co., Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR OCT 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

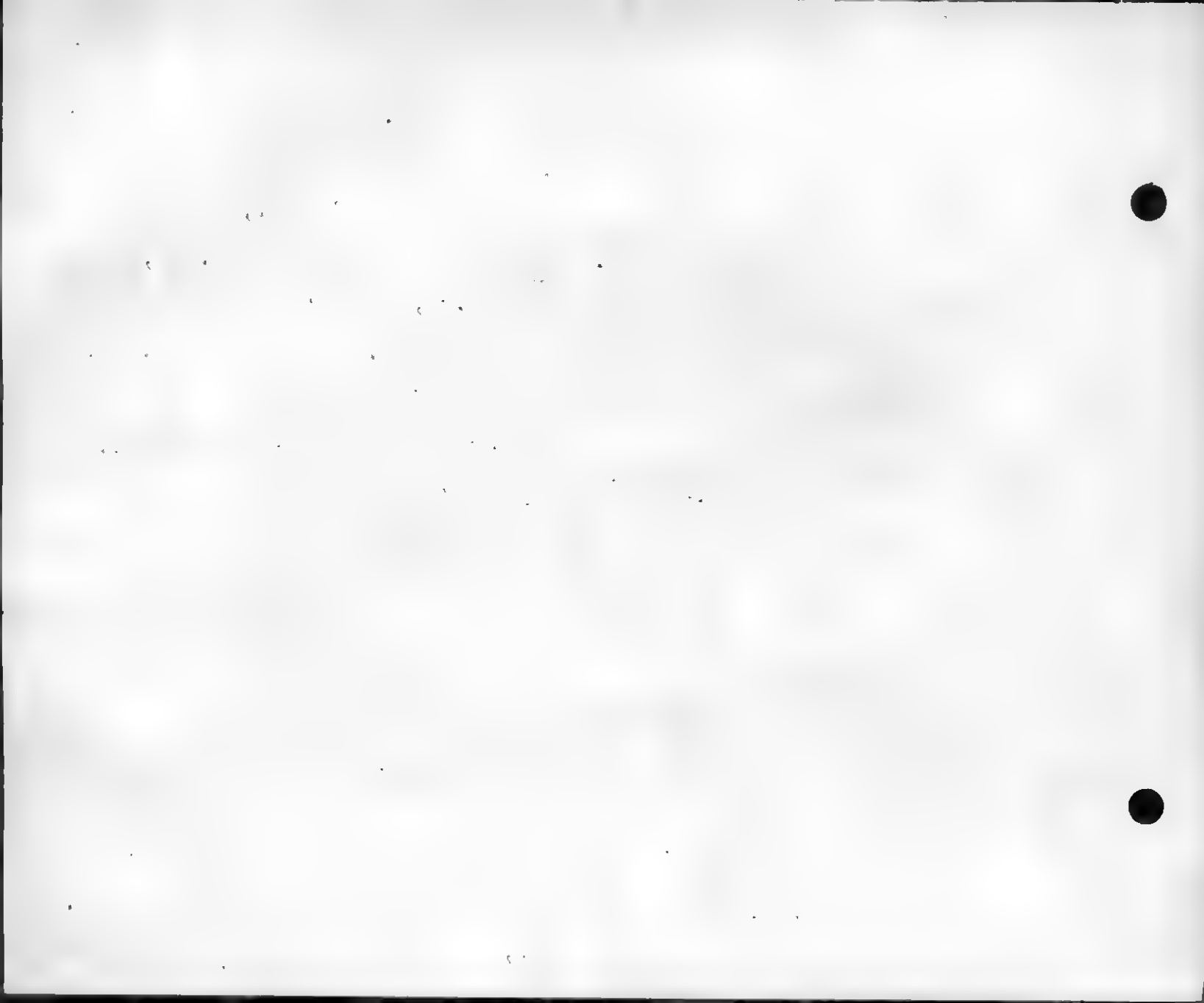


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 4-64

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.											
CERTIFICATE OF DEATH											
13540											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh				c. LENGTH OF STAY IN 1b 21 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost Nursing Home						d. STREET ADDRESS 1105 Elban Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle R. Last McGee			4. DATE OF DEATH Month Oct. Day 8, Year 1967								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1890		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George McGee						14. MOTHER'S MAIDEN NAME Elizabeth Mark					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 		17. INFORMANT Address Virginia McGee 6010 Falkirk Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 1532 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) precipitated by ascending DUE TO (c) Calon										INTERVAL BETWEEN ONSET AND DEATH 6 hrs 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 8/11, 1967 to 10/8, 1967 , that (I) (we) last saw the deceased alive on October 1967 , and that death occurred at 2 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles F. O'Donnell						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/10/67			
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell						22d. ADDRESS 7301 York Rd. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-1967		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town or county) (State) Woodlawn, Md.					
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,						25a. REC'D BY REGISTRAR OCT 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

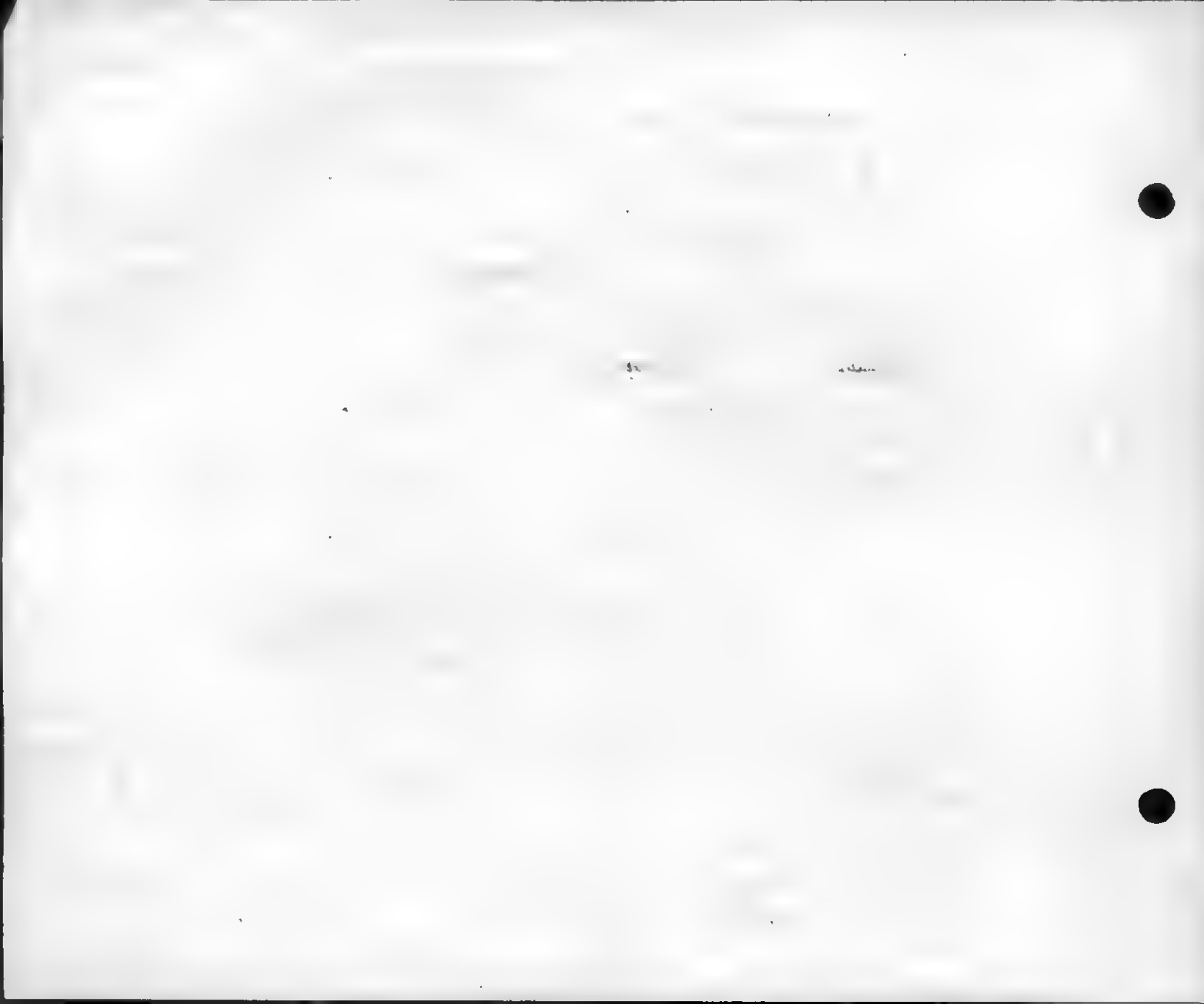
13542

13542

1 PLACE OF DEATH a COUNTY <u>Extonville Woodlawn</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co</u>		c LENGTH OF STAY IN 1b <u>Extonville, Woodlawn</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1727 Langford Road 21207</u>		d STREET ADDRESS <u>1727 Langford Road 21207</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Frank P Mc Kenna (McKenny)</u>		4 DATE OF DEATH Month Day Year <u>Oct 21 1967 19</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 2 1875</u>
9 AGE (In years last birthday) <u>92</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Eastern Box</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>John Mc Kenna</u>		14 MOTHER'S MAIDEN NAME <u>Catherine Farley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no no</u>		16 SOCIAL SECURITY NO <u>217 26 2273</u>	
17 INFORMANT <u>Mrs. Wm. B. Nolan, 1727 Langford Rd</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Disease</u> DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>10/21</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/17</u> , 1967, and that death occurred at <u>10:29</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Dr. P. Williams</u> PROFESSIONAL MEDICAL EXAMINER		22b DATE SIGNED <u>10/23/67</u>	
22c PHYSICIAN'S NAME (Type) <u>5550 BALTIMORE NATIONAL PIKE</u>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10-26-1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>		23d LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>	
24 FUNERAL DIRECTOR <u>Thomas J. Kenny Inc 1600 Hollins St</u>		25a REC'D BY REGISTRAR DATE <u>OCT 25 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20b, 20e, 21
Film #395
12-12-67 mt
2542

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13544

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm				c. LENGTH OF STAY in 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Smith Farm Longreen Pike				d. STREET ADDRESS Smith Farm Longreen Pike			
3 NAME OF DECEASED (Type or print) First EDWARD Middle H. Last MCLEAN JR.				4 DATE OF DEATH Month October Day 22 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-4-1947		9 AGE (in years lost birthday) 20 yrs	10 UNDER 1 YEAR IF UNDER 24 HRS Months 20 Days 20 Hours 20 Min 20	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caddy				10b KIND OF BUSINESS OR INDUSTRY Selfemployed		11 BIRTHPLACE (State or foreign country) Baltimore Co. Md.	
13. FATHER'S NAME Edward McLean				14 MOTHER'S MAIDEN NAME Hilda Beares			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO. 213-52-6713		17. INFORMANT Mrs. Harry Shackelford Address Kingsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 201.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carbon monoxide DUE TO (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Unknown/ Apparently sat in car with defective system			
20c TIME OF INJURY Month, Day, Year Hour 10:30 pm 10-22 19 67				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Unknown car	
				20f (City or town) Glen Arm (County) Balto. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles S. Springate, M.D.				ASSISTANT MED. EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street city, town or county) October 23, 1967			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10-26-1967		23c NAME OF CEMETERY OR CREMATORY Fork Methodist Cemetery		23d LOCATION (City or Town) (County) (State) Fork, Md.	
24 FUNERAL DIRECTOR Lassal Funeral Home				25a REC'D BY REGISTRAR OCT 27 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. Page 2 of 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7 61

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3040
CERTIFICATE OF DEATH

Item #4 Film #G393 10/16/67 ph

13548

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>IVK HALL NURSING HOME</u>		d. STREET ADDRESS <u>1322 WILSON PT. RD</u>	
3. NAME OF DECEASED (Type or print) <u>ROSE E McNeilly</u>		4. DATE OF DEATH <u>Oct. 3 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> Hours <u>19</u> Min. <u>67</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>NEW JERSEY</u>	
13. FATHER'S NAME <u>JAMES FINN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>EDITH TEMPLE</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>MARY KNACKEL</u> Address <u>202 STEVENS RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO (b) <u>Art. sclerotic cerebrovasc. disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Diabetes mellitus</u> DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month <u>10</u> Day <u>3</u> Year <u>1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 6 1965</u> to <u>Oct 3 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 3 1967</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis Semenovff</u> M.D.		22b. DATE SIGNED <u>10/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>		22d. ADDRESS <u>2108 OREGON RD BALTIMORE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>	23d. LOCATION (City, town or county) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. CONNELLY SONS</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>300 MACE</u>		DATE <u>OCT 9 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15 44

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a STATE Maryland b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 900 E. Joppa Road		d. STREET ADDRESS 900 E. Joppa Road	
3 NAME OF DECEASED (Type or print) First William Middle Herbert Last Medill		4 DATE OF DEATH Month Oct. Day 30 Year 1967	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1901
9 AGE (In years last birthday) yrs 66		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William F. Medill		14 MOTHER'S MAIDEN NAME Ellen Joynes	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO no	
17 INFORMANT Bessie G. Medill		Address 900 E. Joppa Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic renal carcinoma 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1/67 , 19 to 10/30 , 19 67 , that (I) (we) last saw the deceased alive on 10/27/67 19, and that death occurred at 6:00 P. M, from causes and on the date stated above.			
22a. SIGNATURE James X. Carmody		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Carmody		22d. ADDRESS 3201 N. Charles St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) entombment		23b. DATE THEREOF 11/2/67	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR NOV 9 1967	
ADDRESS 6500 York Road		25b. REGISTRAR'S SIGNATURE Charles Judge	
Balto., Md., 21212			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13545

13549

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c LENGTH OF STAY IN IB <u>15 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chromemine Road</u>		d STREET ADDRESS <u>Chromemine Rd.</u>	
3 NAME OF (Type or print) <u>ELLA</u> <u>VIRGINIA</u> <u>PEKINS</u>		4 DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <input type="checkbox"/> male <input type="checkbox"/> female	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 10, 1897</u>
9 AGE (In years last birthday) <u>70</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Joseph E. Harmon</u>		14 MOTHER'S MAIDEN NAME <u>Ethel L. Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Evelyn Sibley, Reisterstown, Md.</u>		Address <u>Chromemine Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lymphoma - abdominal</u> 2021 DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u> </u>			INTERVA. BETWEEN ONSET AND DEATH <u>3 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> , 19 <u>67</u> , to <u>October 27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>October 27</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Charles E. McWilliams</u>		22b. DATE SIGNED <u>10-29-67</u>	
22c PHYSICIAN'S NAME (Type) <u>C. E. McWilliams, M.D.</u>		22d ADDRESS <u>Reisterstown Maryland</u>	
23a BURIAL, CREMATION, REMOVA (Specify) <u>burial</u>	23b DATE THEREOF <u>Oct. 30, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Pikesville, Md.</u>
24. FUNERAL DIRECTOR <u>H. J. Ellhardt</u>		ADDRESS <u>Owings Mills, Md.</u>	
25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 31 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13548

13550

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence or birthplace) (If outside corporate limits, write RURAL and give nearest town) a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN <u>Randallstown</u> d. STREET ADDRESS <u>3711 Vega Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Helen B. Melville</u>		4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/91</u>	9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during the attending life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Wm. S. Underwood</u>		14. MOTHER'S MAIDEN NAME <u>Emma Nutman</u>		
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) (Yes give war or dates of service) <u>Medical Center</u>		16. SOCIAL SECURITY NO. <u>320-48-9978-571</u>		17. INFORMANT <u>Richard G. Melville</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe CORONARY atherosclerosis-Thrombosis AT CORONARY</u> DUE TO (b) <u>OLD myocardial infarcts (2), left ventricle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Myocardial-coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), 19. WAS AUTOPSY PERFORMED? <u>Terminal Aspiration of Gastric contents into respiratory tree</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18		
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
21. I certify that (I) (this hospital) attended the deceased from <u>10-29-67</u> to <u>10-29-67</u> that (I) (we) last saw the deceased alive on <u>10-29-67</u> and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.				
22a. SIGNATURE <u>Rolando A. Madamba</u>		22b. DATE SIGNED <u>10-29-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MADAMBA</u>		22d. ADDRESS <u>Baltimore Gen Hosp</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/1/67</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Druid Ridge</u>	23d. LOCATION (City, town or county) <u>Pikesville</u>	(State) <u>Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Young Byers Funeral Chapel</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 1, and page 2 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NOV 1 1967

1977

1. *Phragmites australis* (Cav.) Trin. ex Steud.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13551											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WOODLAWN</u>				c. LENGTH OF STAY IN 1b <u>45 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6721 WINDSOR MILL RD.</u>						d. STREET ADDRESS <u>6721 WINDSOR MILL RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>AUGUST</u> Last <u>METT</u>						4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-29-1889</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Mining Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>mining</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>FREDERICK AUGUST METT</u>						14. MOTHER'S MAIDEN NAME <u> </u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Y/N</u>				16. SOCIAL SECURITY NO. <u>216-03-8968</u>		17. INFORMANT <u>Miss Frances Mett</u>				Address <u>DACTO 24201 Md</u> <u>6721 WINDSOR MILL RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEGENERATIVE HEART DISEASE</u> <u>500, 2</u> DUE TO <u>ARRESTICOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>hypertension; arteriosclerosis; atherosclerosis</u> (c) <u>10 years</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 10, 1956</u> to <u>OCT. 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT. 3, 1967</u> , and that death occurred at <u>12:02 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edwin L. Pierpont</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>						22d. ADDRESS <u>8704 LIBERTY RD. Balto, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY - BALTO - MD -</u>				23d. LOCATION (city, town or county) (State) <u>BALTO - MD -</u>			
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>						ADDRESS <u>4600 Liberty Heights Ave.</u>		25a. REC'D BY REGISTRAR <u>1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

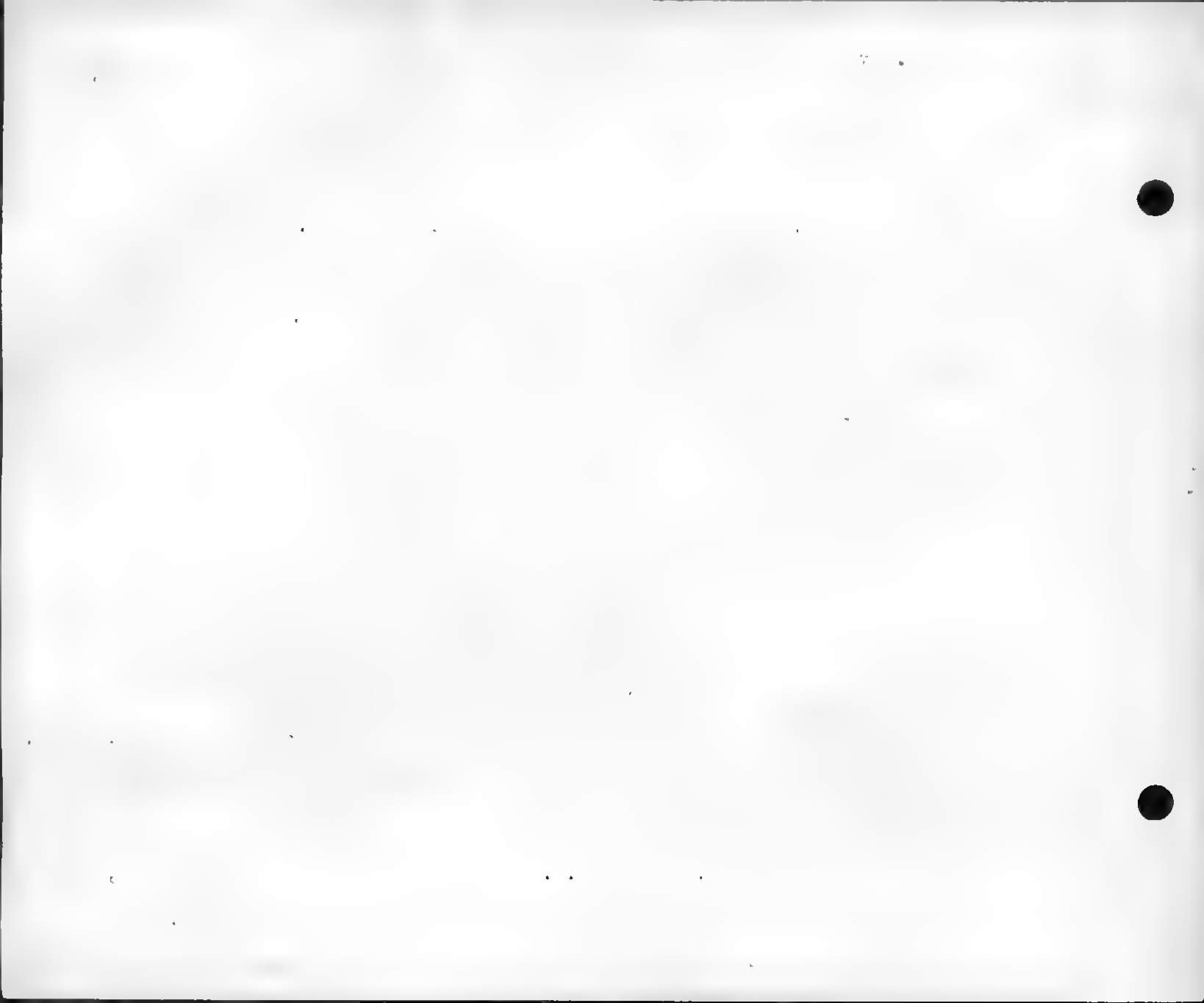
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13543

13552

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b Towson	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Lombardy Ct.		d STREET ADDRESS 6 Lombardy Ct.	
3 NAME OF DECEASED (Type or print) First Middle Last CHARLES PARKER MICHEL		4 DATE OF DEATH Month Day Year 10 4 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 23, 1948
9 AGE (in years last birthday) yrs 19		10 IF UNDER 1 YEAR Months Days Hours Min 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Student		10b KIND OF BUSINESS OR INDUSTRY In School	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Harry O. Michel		14 MOTHER'S MAIDEN NAME Mary Parker	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No one		16 SOCIAL SECURITY NO one	
17 INFORMANT Family Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of the chest DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subject shot himself in the chest			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject shot himself in the chest	
20c TIME OF INJURY Month, Day Year Hour a.m. ? ? 19 p.m. ? ?	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f (City or town) (County) (State) Towson Balto. Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED October 4, 1967	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b DATE THEREOF Oct. 5, 1967	23c NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d LOCATION (City or town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		25a REC'D BY REGISTRAR OCT 9 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13553

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Wilson</u> c. LENGTH OF STAY in lb <u>520 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mount Wilson State Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Res. den. before adm. on) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> d. STREET ADDRESS <u>321 E. CHURCH ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>ROBERT OTIS MILLBERRY</u> First Middle Last S. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-8-08</u> 9. AGE (In years last birthday) <u>58</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		4 DATE OF DEATH <u>10/18/67</u> Month Day Year 13. FATHER'S NAME <u>HENRY MILLBERRY</u> 14. MOTHER'S MAIDEN NAME <u>LIZZIE</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>217-10-0363</u> 17. INFORMANT <u>Records at Mt. Wilson State Hospital</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FAR ADVANCED PULMONARY</u> DUE TO <u>TUBERCULOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>COR PULMONALE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>TWO YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>66</u> , to <u>10-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-18</u> , 19 <u>67</u> , and that death occurred at <u>10:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>William Newcomer</u> 22c. PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>		22b. DATE SIGNED 22d. ADDRESS <u>Mount Wilson, Maryland</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24. FUNERAL DIRECTOR <u>Charles Hickman</u>		23b. DATE THEREOF <u>10-23-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u> ADDRESS <u>Fredrick Md</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>10 OCT 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12548

1355-1

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN TB 12 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3520 Louth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First David Middle W. Last Miller Sr.		4 DATE OF DEATH Month October Day 3 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 29, 1906
9. AGE (In years last birthday) 60 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Slusher		10b. KIND OF BUSINESS OR INDUSTRY American Standard	11 BIRTHPLACE (State or foreign country) Ohio
12 CITIZEN OF WHAT COUNTRY? U. S. A.		13 FATHER'S NAME Bert Miller	
14 MOTHER'S MAIDEN NAME Susie Niswonger		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 218 05 2404		17 INFORMANT (Name) Mrs. Dorothy Miller, 3520 Louth Rd. Dundalk, Md. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO A-S-C-V-Disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE lost Hypertensive C-V-Disease (b) 3 yrs (c) 3 yrs			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED ACTUAL SIGNATURE M. Davis M.D. EXAMINER'S NAME (Type) Melvin B. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. Dundalk, Md. 21222 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL OR CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 10/6/67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. Cem.	23d. LOCATION (City or town) (County) (State) Dorsey, Maryland
24 FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G-804 1075 107 R1

CERTIFICATE OF DEATH

13550

13555

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
c. LENGTH OF STAY IN TB <u>LIFE</u>		d. STREET ADDRESS <u>2812 Taylor Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2812 Taylor Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>F</u> Last <u>Miller</u>		4 DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27, 1889</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE MAN</u>		9b. AGE (in years and months) <u>78 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Dept</u>	
11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Thomas M Miller</u>		14 MOTHER'S MAIDEN NAME <u>ANNA B RAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>212-40-7229</u>	
17 INFORMANT <u>Caroline Miller</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal lobor pneumonia</u> <u>4201</u> DUE TO (b) <u>Left hemiplegia</u> DUE TO (c) <u>Cardio-vascular renal disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion - 1945</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963 to Oct. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21, 1967</u> , and that death occurred at <u>10:30 AM</u> from causes and on the date stated above.			
22a SIGNATURE <u>C. W. Bacon</u>		22b DATE SIGNED <u>10/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>		22d. ADDRESS <u>2810 Taylor Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>BURIAL</u>		<u>OCT 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>MORELAND MORIAL</u>		<u>BALTO MD.</u>	
24 FUNERAL DIRECTOR <u>CHAS. F. EVANS & SON</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8802 Hartford Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 24 1967</u>		DATE <u>OCT 24 1967</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

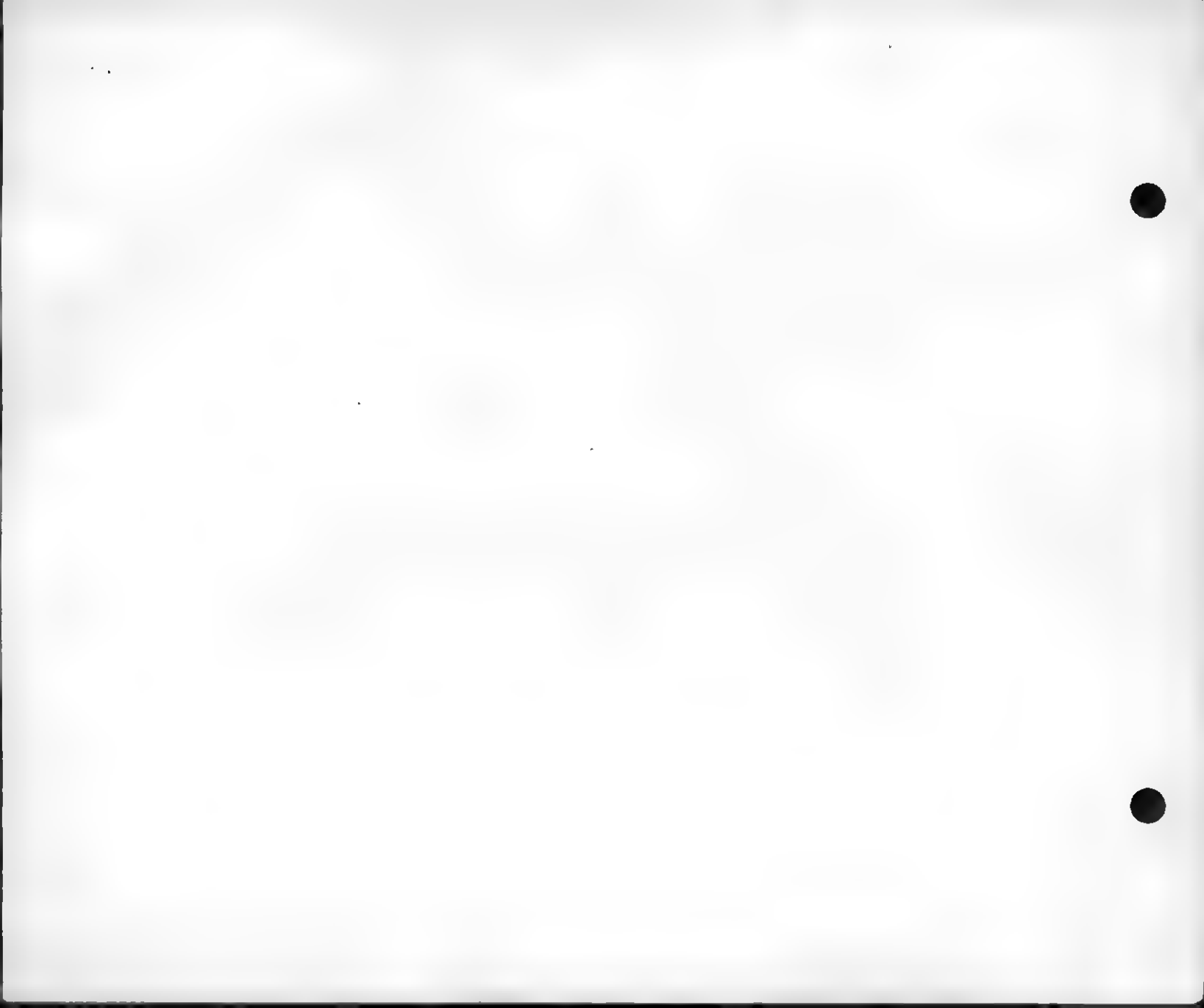
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13551

13556

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balt. Medical Center</u>				d. STREET ADDRESS <u>334 Radnor Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stanley Joseph Miller</u>				4. DATE OF DEATH Month Day Year <u>10 28 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-23</u>	9. AGE (In years last birthday) <u>44</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scully Rubber Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Miller</u>				14. MOTHER'S MAIDEN NAME <u>Genevieve Miller? ANTOINETTE?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW II</u>		16. SOCIAL SECURITY NO. <u>216-18-0032</u>		17. INFORMANT <u>Patient's chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma sigmoid colon</u> 1005 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastases to lung, liver and bone.</u> DUE TO (c)						INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23</u> , 19 <u>67</u> , to <u>Oct 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 28</u> , 19 <u>67</u> , and that death occurred at <u>2:40</u> P.M., from causes and on the date stated above							
22a. SIGNATURE <u>M. Isabelle MacGregor</u> MD				22b. DATE SIGNED <u>10-28-67</u>		22c. PHYSICIAN'S NAME (Type) <u>DR. STUART SUNDAY</u>	
22d. ADDRESS <u>Greater Baltimore Medical Center</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>BURIAL</u>		<u>11-2-1967</u>		<u>HOLY ROSARY CEMETERY</u>		<u>BALTO MD</u>	
24. FUNERAL DIRECTOR <u>JOHN M WEBER & SONS INC 4015 CHESTER ST.</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13552

13557

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annsie</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6411 Barbours Rd</u>				d. STREET ADDRESS <u>6411 Barbours Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Woodrow D. Miller</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15 1920</u>	9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carpell Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David R. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Winnie M Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>219 012032</u>		17. INFORMANT <u>Helen T Miller</u> Address <u>6411 Barbours Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of sigmoid colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH Months <u>10</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/4/</u> , 19 <u>67</u> , to <u>10/12/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>September 6</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Kemper Owens</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Kemper Owens, M.D.</u>				22d. ADDRESS <u>Six East Read Street 21202</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 14 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Uniontown Lutheran</u>		23d. LOCATION (City, town or county) (State) <u>Uniontown Carpell Co Md</u>	
24. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Be Hb Md</u>		25b. REGISTRAR'S SIGNATURE <u>Johnnie Jones</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

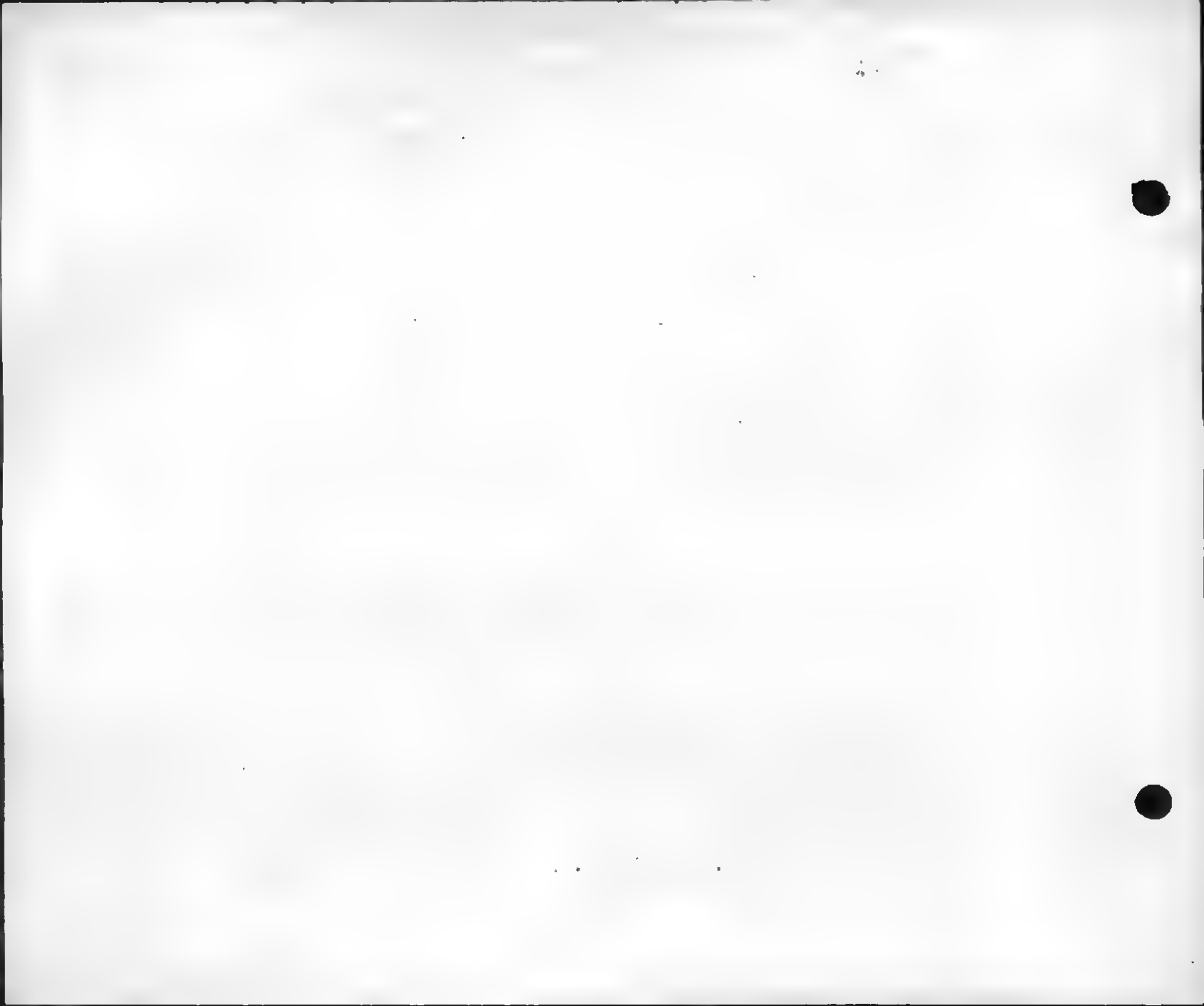
CERTIFICATE OF DEATH

13559

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Baltimore 21236 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) a. STATE Maryland b. COUNTY Baltimore 21236 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21236 d. STREET ADDRESS 3802 Joppa Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Edna Jane MOON		4 DATE OF DEATH Month Day Year October 5, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 6, 1890
9 AGE (In years lost birthday) 77 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E.D. Owen Davis, Sr.		14 MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 217246934	
17 INFORMANT Mr. Leroy Burkhear, Sr.		Address 8 W. Elm Ave Balto 6 Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal Obstruction 1058 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of colon with metatasis DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that no (this hospital) attended the deceased from 10/4/ , 19 67 , to 10/5/ , 1967, that no (we) last saw the deceased alive on 10/5/ 19 67 , and that death occurred at 1:21 PM , from causes on and on the date stated above.			
22a. SIGNATURE Lawrence T. Misanik, M.D.		22b. DATE SIGNED October 5, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence T. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/9/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Cem.	23d LOCATION (City or Town) (County) (State) Baltimore Balto. Md.
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.		25a. REC'D BY REGISTRAR OCT 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13554

13560

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3316 Kenyon Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELVA F. MOONEY First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 18, 1887 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (n years day birthday) 80 yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			4. DATE OF DEATH October 28, 1967 Month Day Year IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.				
13. FATHER'S NAME Charles Warnbach 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-22-4806 B 17. INFORMANT Mrs. Katherine Loeffler Address 408 S. Bouldin St.		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Hypertensive heart disease DUE TO (c) Diabetes mellitus, moderate			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital telangiectasia multiple epistaxis.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from July 1946, to 28 Oct., 1967, that (I) last saw the deceased alive on 28 Oct., 1967, and that death occurred on 28 Oct., 1967, at 7:55 P.M., from causes and on the date stated above. 22a. SIGNATURE Robert Z. Berry M.D. 22b. DATE SIGNED 29 Oct., 1967 22c. PHYSICIAN'S NAME (Type) Robert Z. Berry 22d. ADDRESS Medical Arts Building 23a. BURIAL, CREMATION, or other disposition (Specify) Burial 23b. DATE THEREOF Oct. 31, 1967 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. 24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road. 25a. REC'D BY REGISTRAR NOV 2 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 18-20 Film 395
11-28-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13555

CERTIFICATE OF DEATH

13561

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>39 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>31 S. Carey St. Balto, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>B</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>67</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-15</u>
9 AGE (In years last birthday) <u>52</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alfred B. Moore (deceased)</u>	
14 MOTHER'S MAIDEN NAME <u>Elizabeth Sheeren</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17 INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>75.3.1</u> DUE TO <u>Aspiration of Food</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral defect, congenital</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>terminal</u> <u>28 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Aspiration during feeding</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:35</u> <u>21 Oct</u> <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>Rosewood Hosp.</u>		20f. (City or town) (County) (State) <u>Owings Mills Balto. Md.</u>	
21. I certify that I (this hospital) attended the deceased from <u>29 Aug</u> , 19 <u>67</u> to <u>21 Oct</u> , 19 <u>67</u> , that I (we) last saw the deceased alive on <u>21 Oct</u> , 19 <u>67</u> , and that death occurred at <u>8:50 AM</u> , from causes and on the date stated above.		22a. SIGNATURE <u>Richard A. Jones</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <u>21 Oct 67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard A. Jones</u>	
22d. ADDRESS <u>Rosewood State Hosp.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREON <u>10/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>		24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc 5305 Harford Rd</u>	
25a. REC'D BY REGISTRAR <u>OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1950

1951

14 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13562

13556

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville-Timonium 21093			c. LENGTH OF STAY IN 1b Years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1019 West Seminary Avenue			d. STREET ADDRESS 1019 West Seminary Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SARA K. MORAN			4. DATE OF DEATH OCTOBER 11, 1967		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 5, 1893		9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY Dept. Stores		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Christian Kogler			
14. MOTHER'S MAIDEN NAME Margaret Shuster		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-07-9523A		17. INFORMANT Address Mrs. Eleanor Baum, Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Carcinoma of Uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) typ (c)					INTERVAL BETWEEN ONSET AND DEATH 2 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from 7 October 1967 to 10/11, 1967 , that (1) he lost soul the deceased alive on 10/9, 1967 , and that death occurred at 10:00 AM , from causes and on the date stated above					
22a. SIGNATURE Charles F. O'Donnell		22b. DATE SIGNED 10-11-67		22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell	
22d. ADDRESS 7501 York Rd 21204		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson,		1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR OCT 13 1967	
25b. REGISTRAR'S SIGNATURE [Signature]					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/67

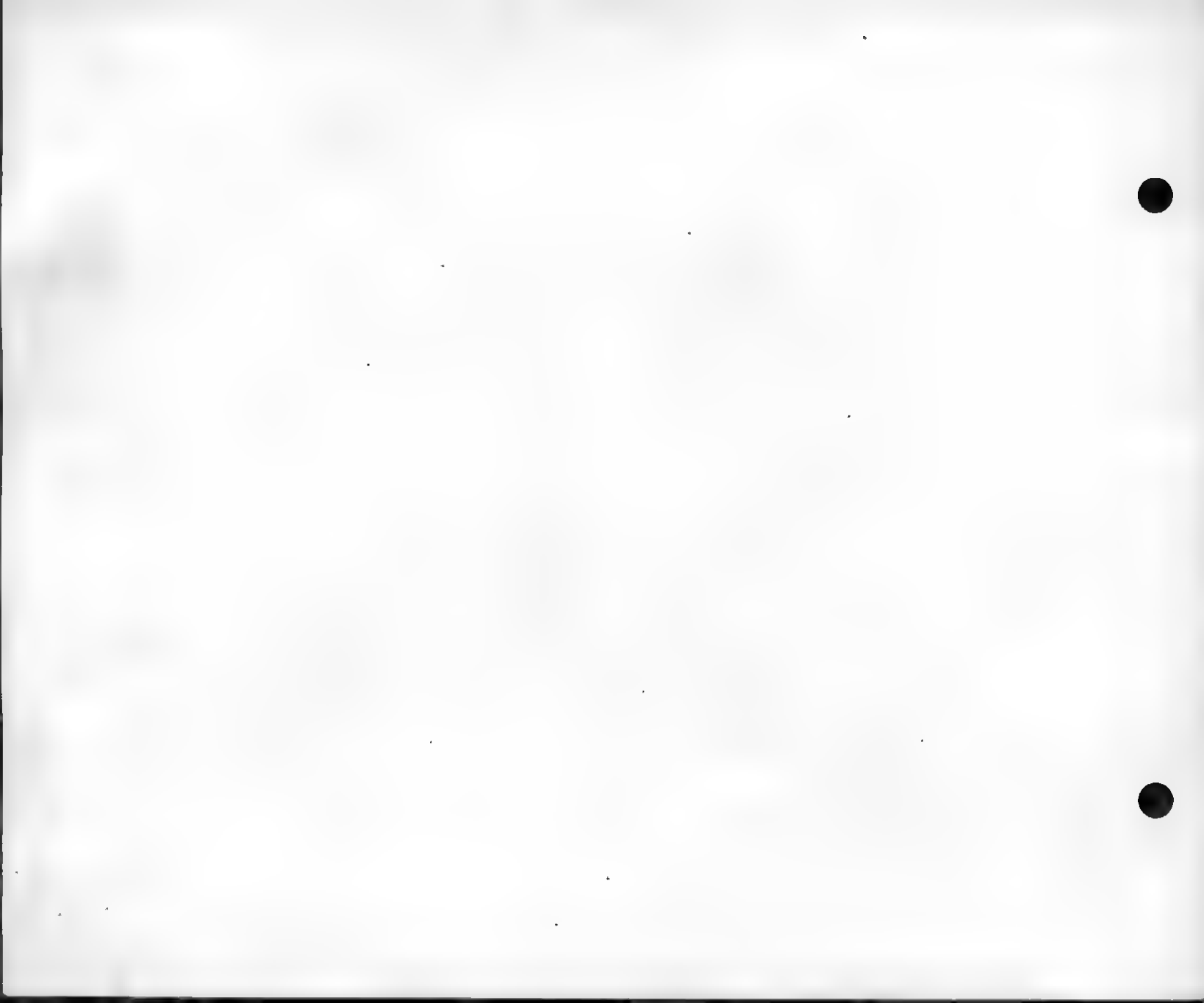
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13557

13563

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Unknown b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN 1b Unknown Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6300 block Liberty Rd.		d STREET ADDRESS 6223 Liberty Heights Terraces	
3 NAME OF DECEASED (Type or print) LENORA MORRIS		4 DATE OF DEATH Month October Day 31 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/16-1907/1897
9 AGE (in years last birthday) 70 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (State or foreign country) Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John H. Bowen		14 MOTHER'S MAIDEN NAME Emma Francis	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT John Morris		Address St. Rt. 1, Box 147B, Pasadena, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) 8124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject was pedestrian struck by auto	
20c TIME OF INJURY Month, Day, Year 9:30 PM 10 31 1967		20d INJURY OCCURRED While <input type="checkbox"/> or work, Not While <input checked="" type="checkbox"/> or work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Street		20f (City or town) (County) (State) Baltimore Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson		22. DATE SIGNED November 1, 1967	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) November 1, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11/4-1967	23c NAME OF CEMETERY OR CREMATORY Mt. Zion	23d LOCATION (City or town) (County) (State) Freeland Balto. Co. Md.
24 FUNERAL DIRECTOR Frank H. Berty		25a REC'D BY REGISTRAR NOV 6 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PA-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

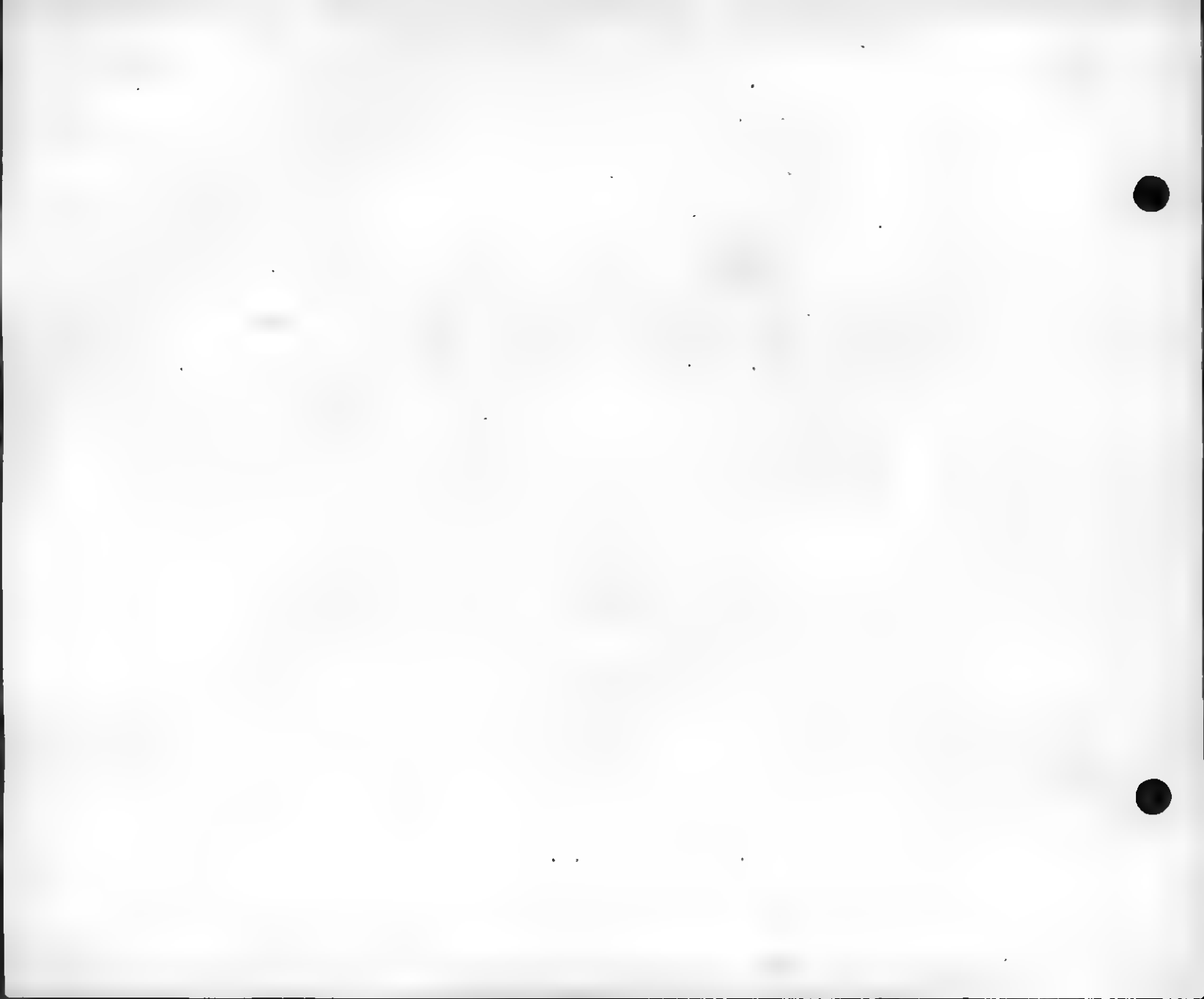
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13555

13564

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY in 1b about 2 wks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 418 Virginia Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last SHERMAN W. MORRIS		4 DATE OF DEATH Month Day Year October 14, 1967	
5 SEX Male	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/20
9 AGE (In years, last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Furniture Factory	
11 BIRTHPLACE (State or foreign country) Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Gas. W. Morris		14 MOTHER'S MAIDEN NAME Alma Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W.W.H.		16 SOCIAL SECURITY NO 172-12-5565	
17 INFORMANT Alice Morris		Address 118 Lincoln Ave. Lutherville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1134 Atlanto-occipital disarticulation with brainstem injury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pedestrian struck by auto		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Pedestrian struck by auto	
20c. TIME OF INJURY Month, Day, Year Hour XXXX p.m. 7:55 10-14 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Towson Baltimore Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED October 14, 1967	
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/67	
23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Sam. S. Chatman		25a. REC'D BY REGISTRAR OCT 17 1967	
ADDRESS 1701 McCall St. Balto. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



13553

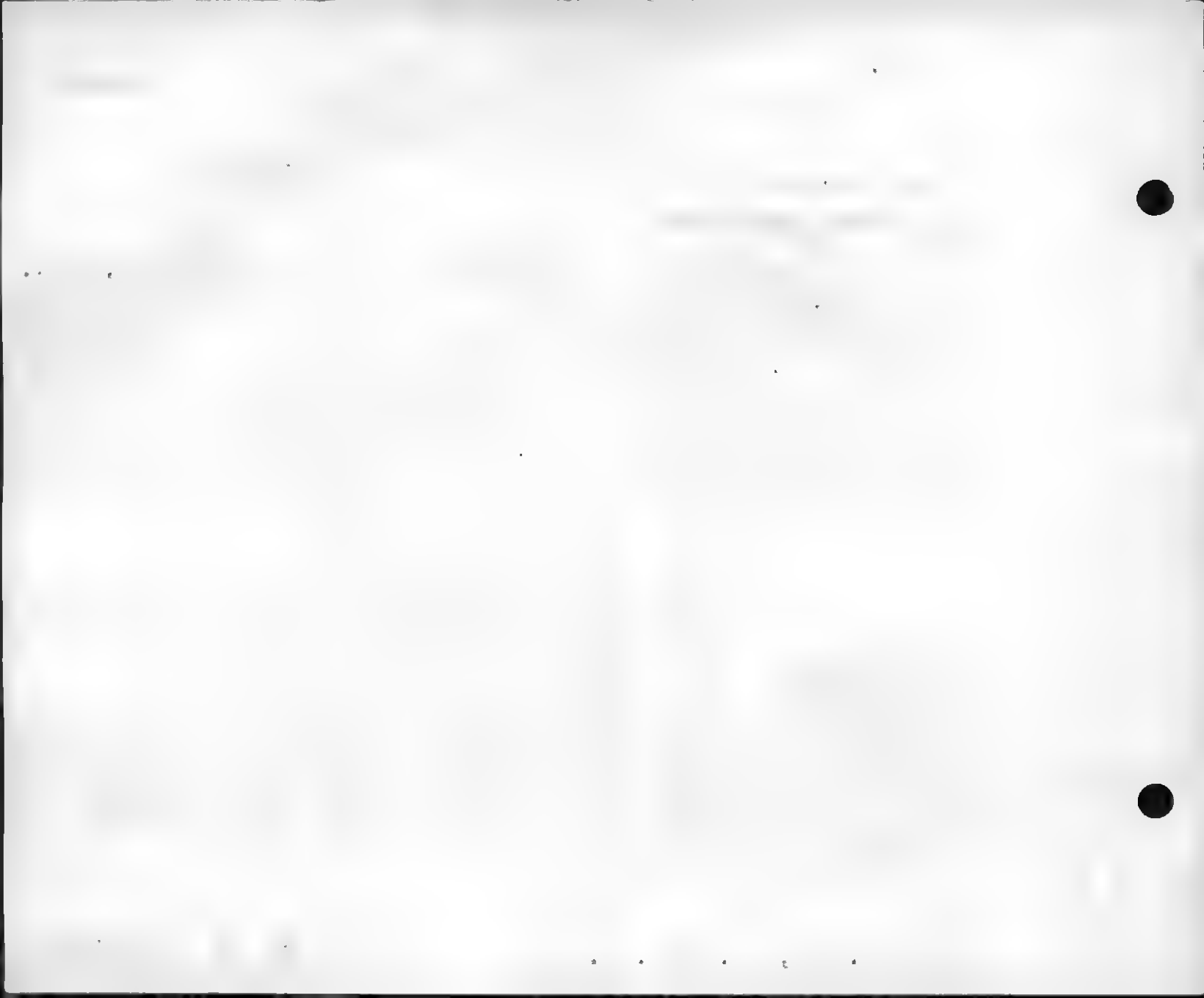
CERTIFICATE OF DEATH

13565

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b Baltimore 21212		d. STREET ADDRESS 6100 Edlyne Road	
3. NAME OF DECEASED (Type or print) PATRICK H. MORRISON		4. DATE OF DEATH Month October Day 18 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/30/1907
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months 10 Days 18 Hours 18 Min 00	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Blaine Morrison		14. MOTHER'S MAIDEN NAME Catherine Flatley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214 18 7677	
17. INFORMANT Mrs. Maurice S. Bozel		Address 6100 Edlyne	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with DUE TO (b) Cerebral Metastases DUE TO (c) Cerebral Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 16, 1967 to Oct 18, 1967 , that (I) (we) last saw the deceased alive on Oct 13, 1967 , and that death occurred at 4:50 A.M. from causes and on the date stated above			
22a. SIGNATURE William H. Fusting		22b. DATE SIGNED 10-19-67	
22c. PHYSICIAN'S NAME (Type) William H. Fusting		22d. ADDRESS 4230 Loch Raven Blvd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/21/67	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.	23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR OCT 19 1967	
25b. REGISTRAR'S SIGNATURE John R. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

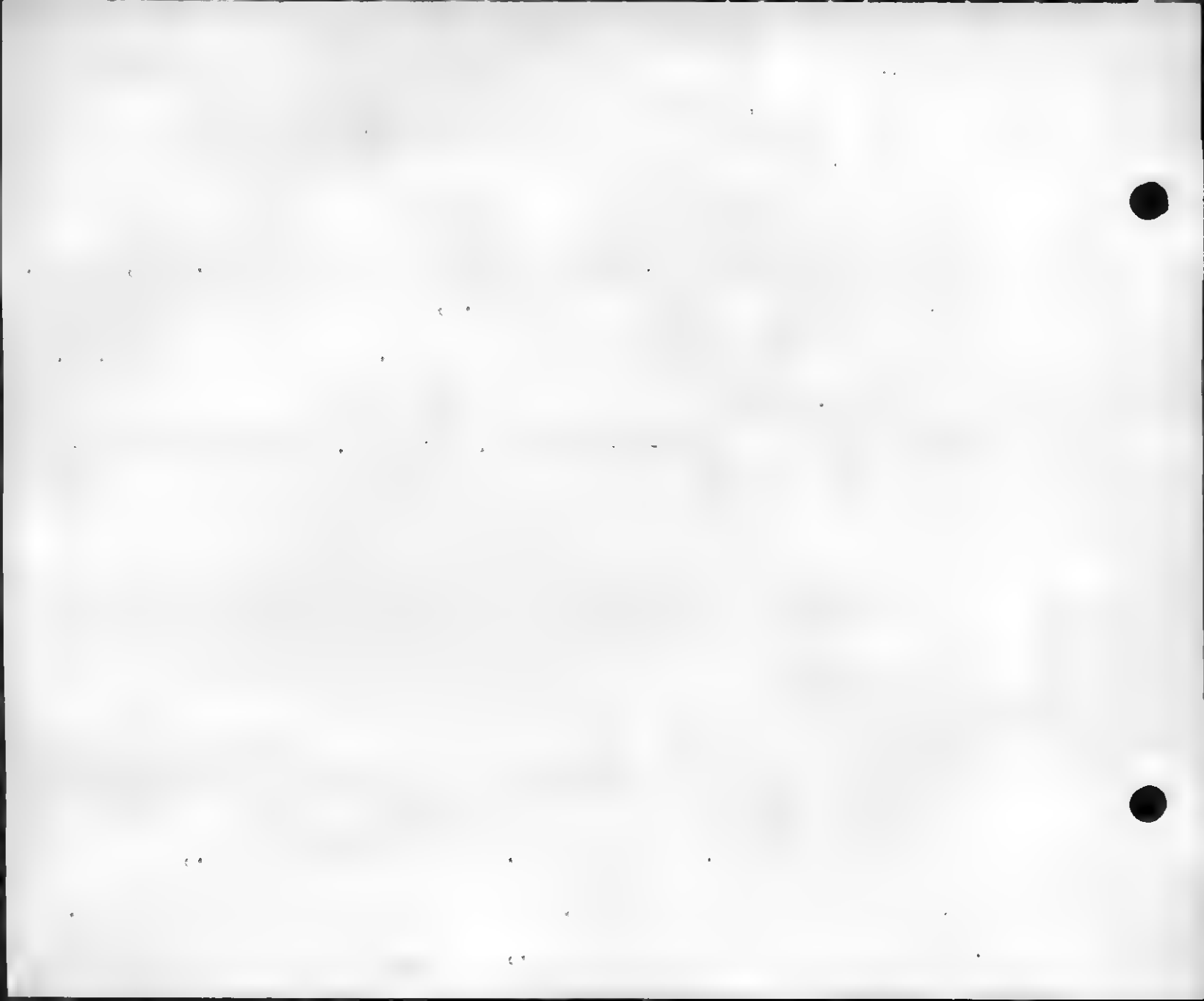
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Merridale				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Merridale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 635 Plymouth Road				d. STREET ADDRESS 635 Plymouth Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Joseph Murphy				4. DATE OF DEATH Month Day Year Oct. 15, 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 6, 1896		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Railway Express		11. BIRTHPLACE (County & State, or foreign country) BaltoMd.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James N. Murphy				14. MOTHER'S MAIDEN NAME Rose McKeever							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 714-03-4100		17. INFORMANT Address Mrs. Matilda L. Murphy 635 Plymouth Rd					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Atherosclerosis DUE TO (c) Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 1 day 23 hr 5 hr?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-15-1966 , to 10-15-1967 , that (I) (we) last saw the deceased alive on 10-17-1967 , and that death occurred at 11 P. M, from the causes and on the date stated above.											
22a. SIGNATURE Wilmer K. Gallagher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Sr.				22d. ADDRESS 6209 Frederick Ave.,							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-1967		23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION (City, town or county) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,						25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

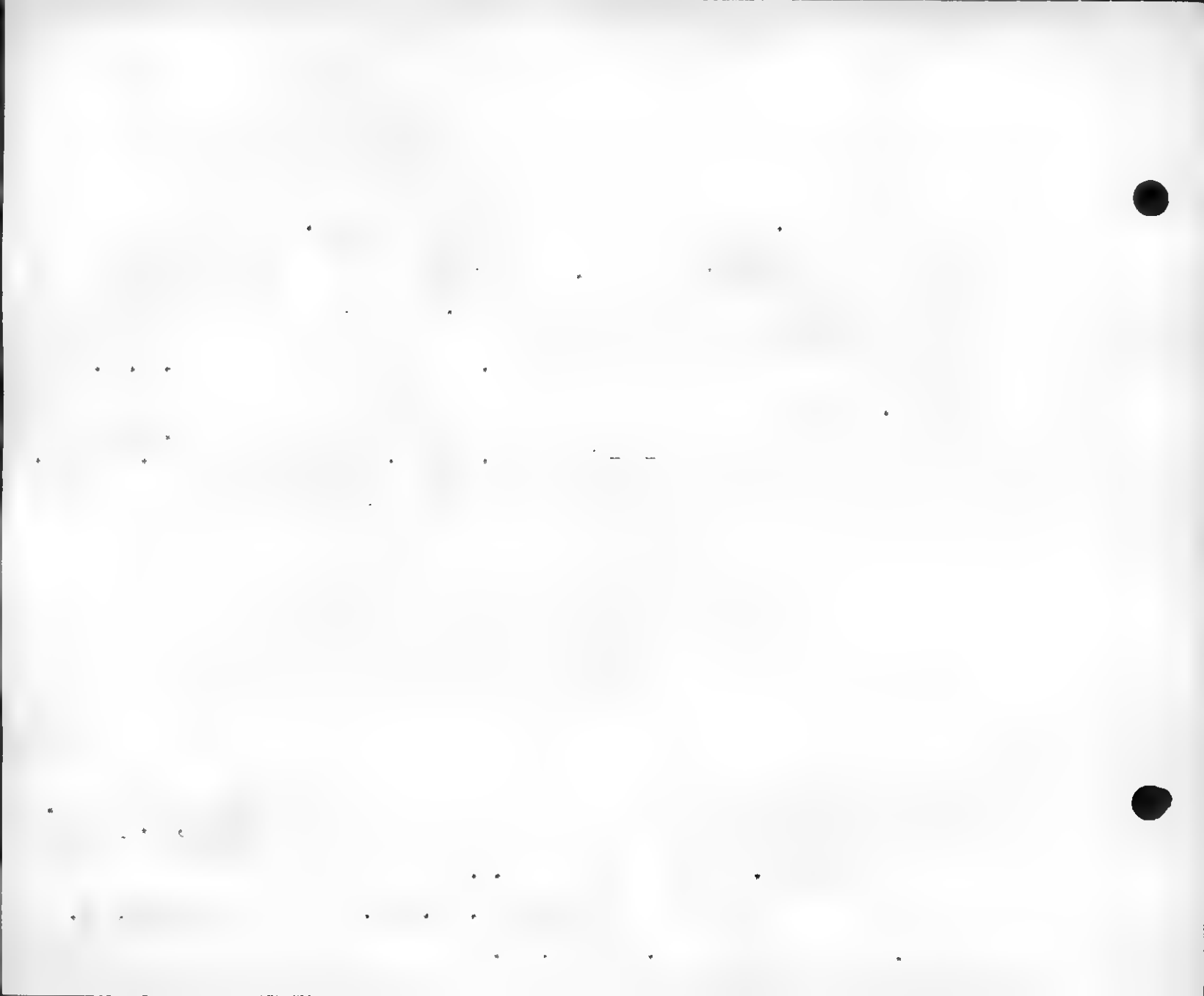
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13561

13567

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c LENGTH OF STAY IN MD 35 Years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 705 Wise Ave.			d STREET ADDRESS 705 Wise Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First William Middle J. Last Myatt			4 DATE OF DEATH Month October Day 10 Year 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 29, 1896	9 AGE (In years lost birthday) 71 yrs	F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11 BIRTHPLACE (State or foreign country) Tennessee	
13 FATHER'S NAME John M. Myatt			14 MOTHER'S MAIDEN NAME Tina Yates		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 213-07-5355		17 INFORMANT (Wife) Mrs. Mary C. Myatt, 705 Wise Ave. Dundalk.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 A-S-C-V-Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None			
20c. TIME OF INJURY Month, Day, Year hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M. B. Davis		M.D. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. Dundalk, Md. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 21222 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 21222 Address (Street, City or town, County, State) 22 DATE SIGNED 10/11/67	
23a. BURIAL CREMATION, REMOVAL (a) Burial		23b. DATE THEREOF 10/14/67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. Cem.	
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 13 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

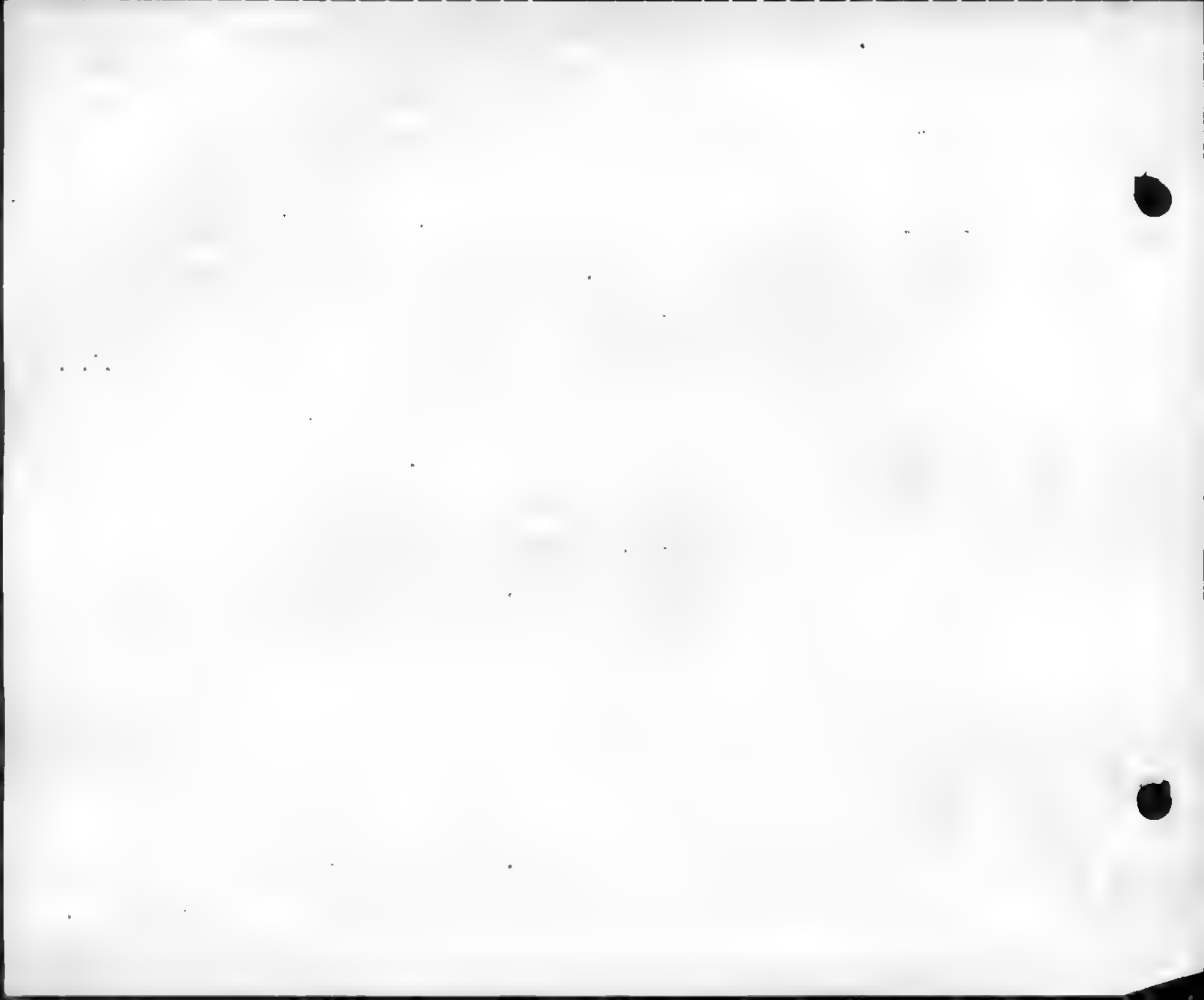
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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13568

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore 21234	
c LENGTH OF STAY IN 1b St. Joseph Hospital		d STREET ADDRESS 4028 Klausmier Ave. Road 21236	
3 NAME OF DECEASED (Type or print) First Middle Last Ella T. NEISER		4 DATE OF DEATH Month Day Year October 31, 1967	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH February 11, 1895
9. AGE (in years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Strong		14. MOTHER'S MAIDEN NAME Virginia R. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 212-26-5802	
17. INFORMANT Charles H. Neiser		Address 4028 Klausmier Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 Cardio-respiratory arrest DUE TO (b) Cerebral hemorrhage DUE TO (c) Hemiplegia, left.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/29/ , 19 67 , to 10/31/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/31/ , 19 67 , and that death occurred at 2:10 P. from causes and on the date stated above.			
22a SIGNATURE Gualberto C. Gokim, Jr. M.D.		22b DATE SIGNED October 31, 1967	
22c PHYSICIAN'S NAME (Type) Gualberto C. Gokim, Jr., M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11-3-1967	23c NAME OF CEMETERY OR CREMATORY Bel Memorial Cemetery	23d LOCATION (City or Town) (County) (State) Bel Air Harford Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 7401 Bel Air Road		DATE NOV 6 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13563

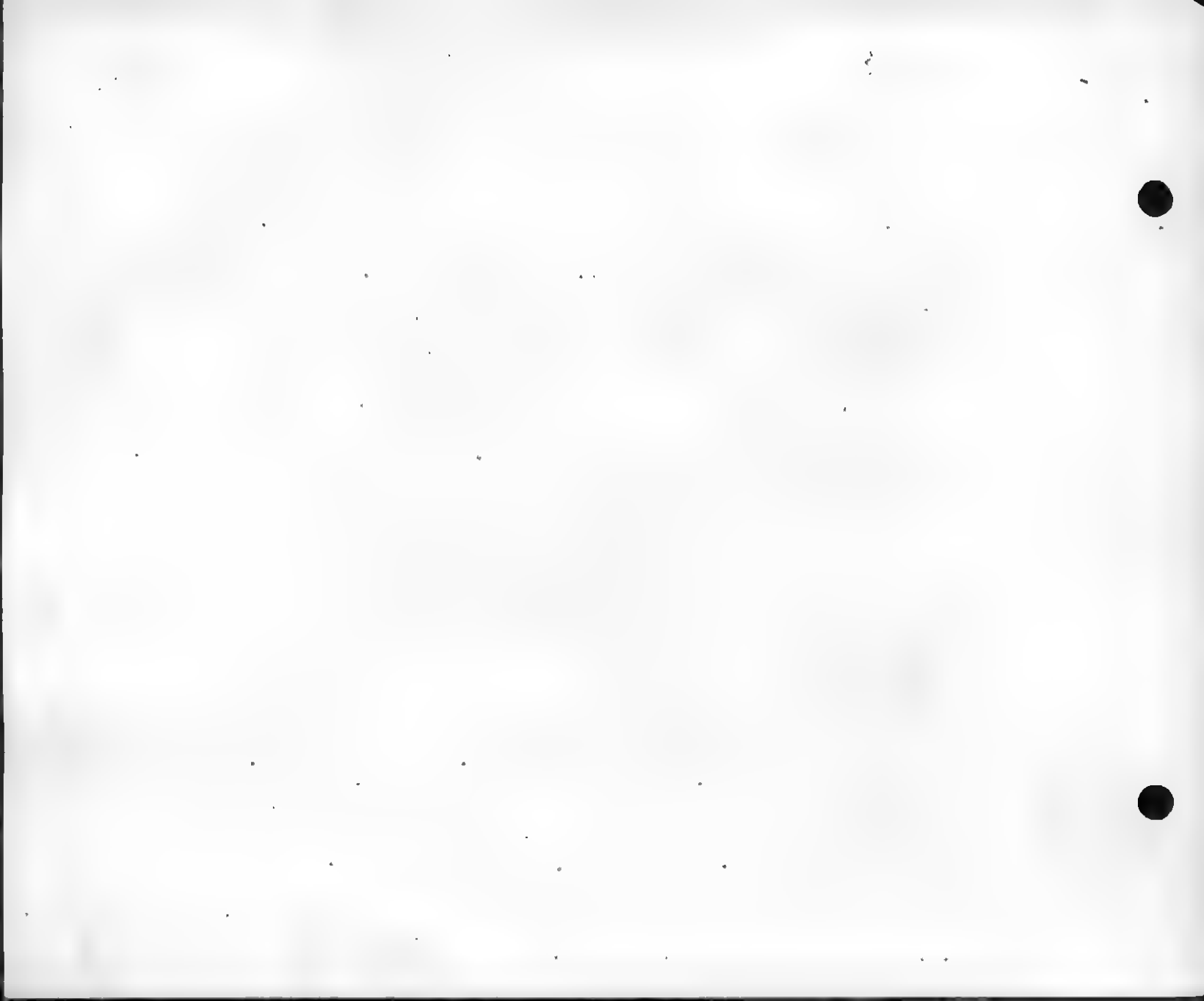
CERTIFICATE OF DEATH

13569

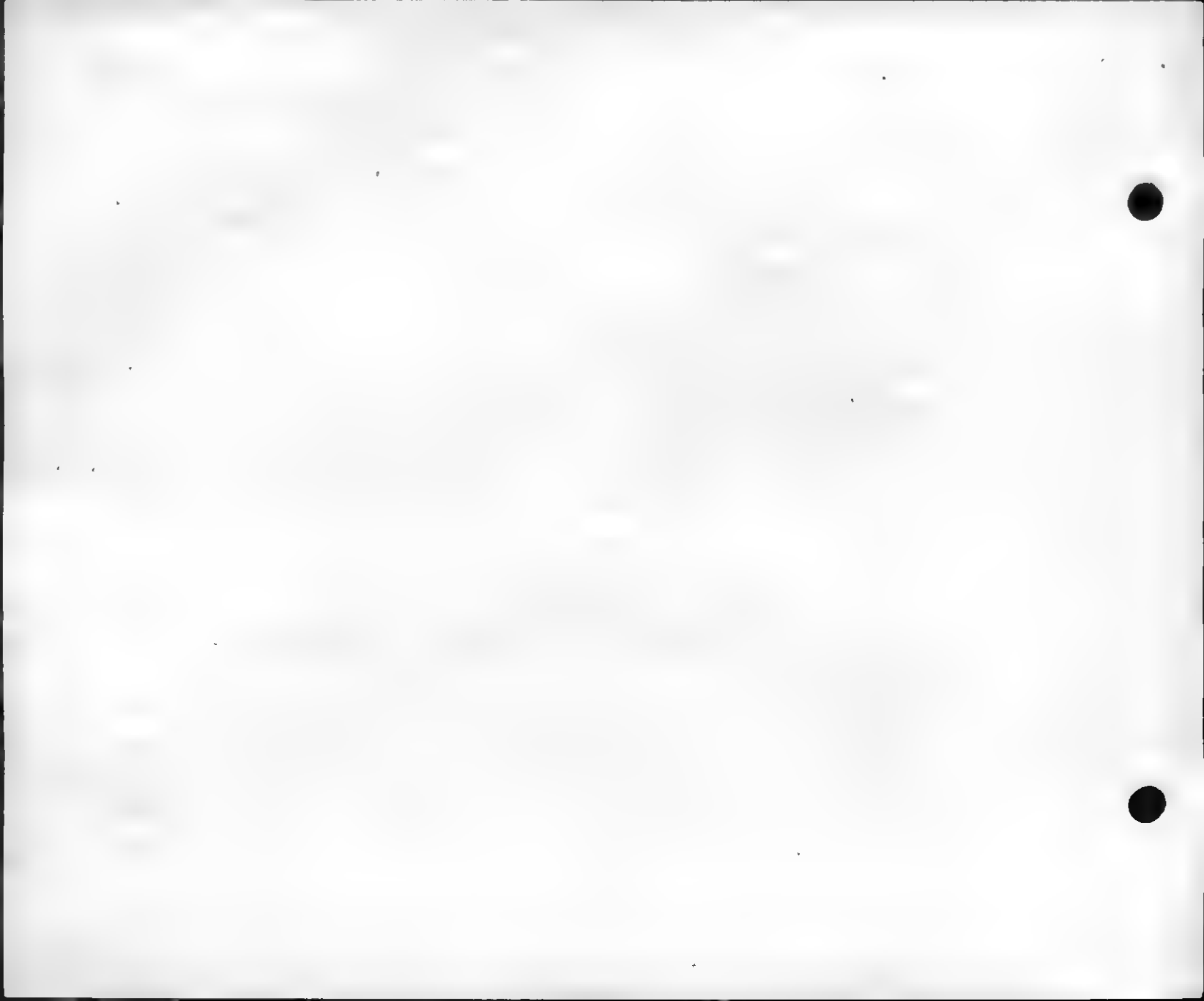
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1653 Nature Rd. 21204	
3. NAME OF DECEASED (Type or print) First JOHN Middle L. Last NEUHAUS SR.		4. DATE OF DEATH Month October Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1899
9. AGE (In years last birthday) 68		10. FUNDING YEAR Months 1 Days 1 Hours 1 Min 1	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		11b. KIND OF BUSINESS OR INDUSTRY Marine	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Neuhaus		14. MOTHER'S MAIDEN NAME Mary A. Hauzzenzol	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215 05 7584	
17. INFORMANT Mrs. Mary Neuhaus		Address 1653 Nature Rd. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia, right cerebrum x 6 11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) cerebral arteriosclerosis DUE TO (c) Diabetes mellitus.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from Oct. 25 , 1967, to Oct. 26 , 1967, that (s) (we) last saw the deceased alive on Oct. 26 , 1967, and that death occurred at 8:30 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Misanik</i>		22b. DATE SIGNED October 27, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-30-67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland. Balto.
24. FUNERAL DIRECTOR Wm.E. Johnson, 8521 Loch Raven Blvd. 21204		25a. REC'D BY REGISTRAR NOV 1 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institut	
a. STATE <i>MARYLAND</i>		a. STATE <i>NEW YORK</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>NEW YORK</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Foxleigh Nursing Home</i>		d. STREET ADDRESS <i>110 BENNETT AVENUE, N.Y.</i> <i>NEW YORK</i>	
3. NAME OF DECEASED (Type or print) <i>Amelia</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. DATE OF DEATH Month <i>10</i> - Day <i>9</i> - Year <i>1967</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-4-1890</i>
9. AGE (In years last birthday) <i>77</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ABRAHAM MEYERSON</i>		14. MOTHER'S MAIDEN NAME <i>SARAH HOROWITZ</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>665-30-6000</i>	
17. INFORMANT <i>115 W. 79th St.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO (b) <i>Coronary Art Disease</i> DUE TO (c) <i>Ser. ym.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Atherosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>66</i> to <i>Oct 9</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Oct 7</i> , 19 <i>67</i> , and that death occurred at <i>6 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Leonard Rotz</i>		22b. DATE SIGNED <i>10/9/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>LEONARD ROTZ, MD</i>		22d. ADDRESS <i>115 W. 79th St.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-11-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>MT. LEBANON</i>		23d. LOCATION (City or Town) (County) (State) <i>RIDGEWOOD, NEW YORK</i>	
24. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 11 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12565

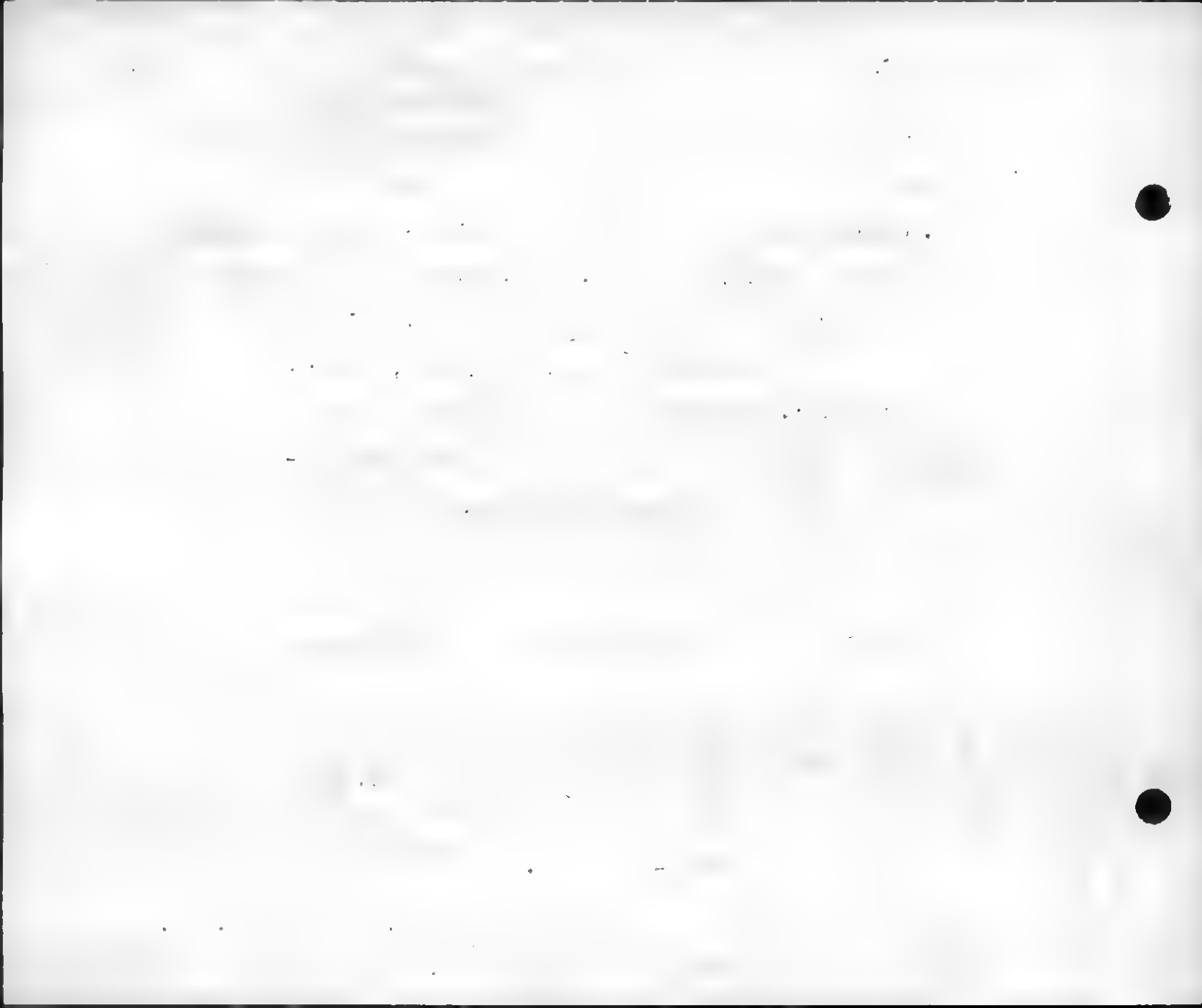
CERTIFICATE OF DEATH

13571

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 2153 Vailthorn Road #21220	
3. NAME OF DECEASED (Type or print) First Middle Last Charles W. NOFSKER		4. DATE OF DEATH Month Day Year October 3 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1941
9. AGE (In years last birthday) 26 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Martin Company	11. BIRTHPLACE (County & State or foreign country) Altoona, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel B. Nofsker	
14. MOTHER'S MAIDEN NAME Helen Wysong		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records-St. Joseph	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 576X Generalized peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal familial polyposis with malignant degeneration.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from September 8, 19 67 to October 3, 19 67 , that (2) (we) last saw the deceased alive on October 3, 19 67 , and that death occurred at 12:20 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED October 3, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/6/67	23c. NAME OF CEMETERY OR CREMATORY Creson Valley Cem.	23d. LOCATION (City or Town) (County) (State) Blair Co. Pa.
24. FUNERAL DIRECTOR Mitchell Wiedefeld Home-6500 York Rd-21212		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
26. BAREFOOT FUNERAL HOME, EAST FREEDOM, PA.		DATE OCT 4 1967	

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12566

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13572

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 603 S. Decker Ave			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOXLEIGH NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FELIX OR FELICE NOTARANGELO				4. DATE OF DEATH Month 10 Day 31 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/83	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min.		11. BIRTHPLACE (County & State, or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER				10b. KIND OF BUSINESS OR INDUSTRY RETIRED			
13. FATHER'S NAME THEODORE NOTARANGELO				14. MOTHER'S MAIDEN NAME MARY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 215-07-1267A			
17. INFORMANT NICHOLAS NOTARANGE				Address 5606 SAGRA RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10-26 , 1967 , to 10-31 , 1967 , that (1) (we) last saw the deceased alive on 10-30 , 1967 , and that death occurred at 8:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE David J. Miller						22b. DATE SIGNED 10-31-67	
22c. PHYSICIAN'S NAME (Type) David J. Miller				22d. ADDRESS Crason Rd - Owings Mills Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/4/67		23c. NAME OF CEMETERY OR CREMATORY HOLUREDEEMER		23d. LOCATION (City, town or county) (State) BALTO MD	
24. FUNERAL DIRECTOR Frank Della Rose				25a. REC'D BY REGISTRAR NOV 2 1967		25b. REGISTRAR'S SIGNATURE William Judge	

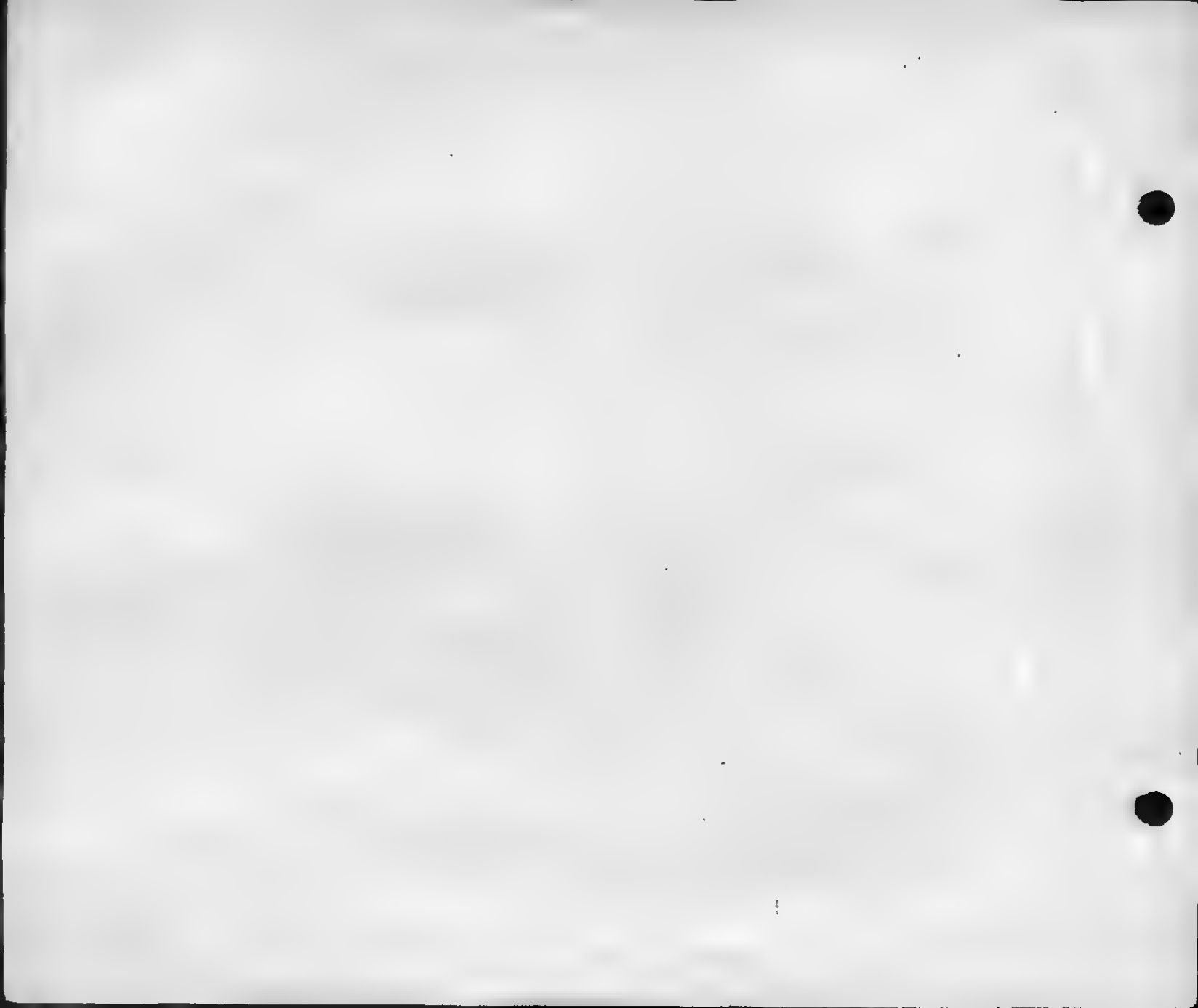


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1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13566									
13573									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>BALTIMORE</u>					a. STATE <u>MARYLAND</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>					b. COUNTY <u>BALTIMORE</u>				
c. LENGTH OF STAY IN TB <u>1</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DUNLAP TOWSON NURSING HOME</u>					d. STREET ADDRESS <u>6634 SANZO ROAD</u>				
3. NAME OF DECEASED (Type or print) <u>SAMUEL I. NOVICK</u>					4. DATE OF DEATH <u>OCT 2 1967</u>				
5. SEX <u>M</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <u>9/4/1890</u>				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) <u>77</u> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>PAINT CO</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>LOUIS</u>					14. MOTHER'S MAIDEN NAME <u>LILLIAN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO <u>002-07-5146</u>				
17. INFORMANT <u>Wife</u>					Address <u>Same</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a.) <u>224-X</u> DUE TO <u>Uremia</u>					<u>2 WKS</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <u>Cerebral Arteriosclerosis</u>					<u>2 yrs</u>				
} DUE TO <u>Generalized Arteriosclerosis</u>					<u>2 yrs</u>				
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary Tract Infection</u> <u>Bronchi pneumonia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1965</u> , to <u>10-2-1967</u> , that (I) (we) last saw the deceased alive on <u>9-30-1967</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>M.W. JACOBSON</u>					22b. DATE SIGNED <u>10/3/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>M.W. JACOBSON MD</u>					22d. ADDRESS <u>6521 REISTERSTOWN RD BALTO MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>					23b. DATE THEREOF <u>10/4/67</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>					23d. LOCATION (City, town or county) (State) <u>BALTO MD</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S Lewis & Son, Inc</u>					25a. REC'D BY REGISTRAR <u>Garrison, Md</u>				
25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>					DATE <u>OCT 5 1967</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

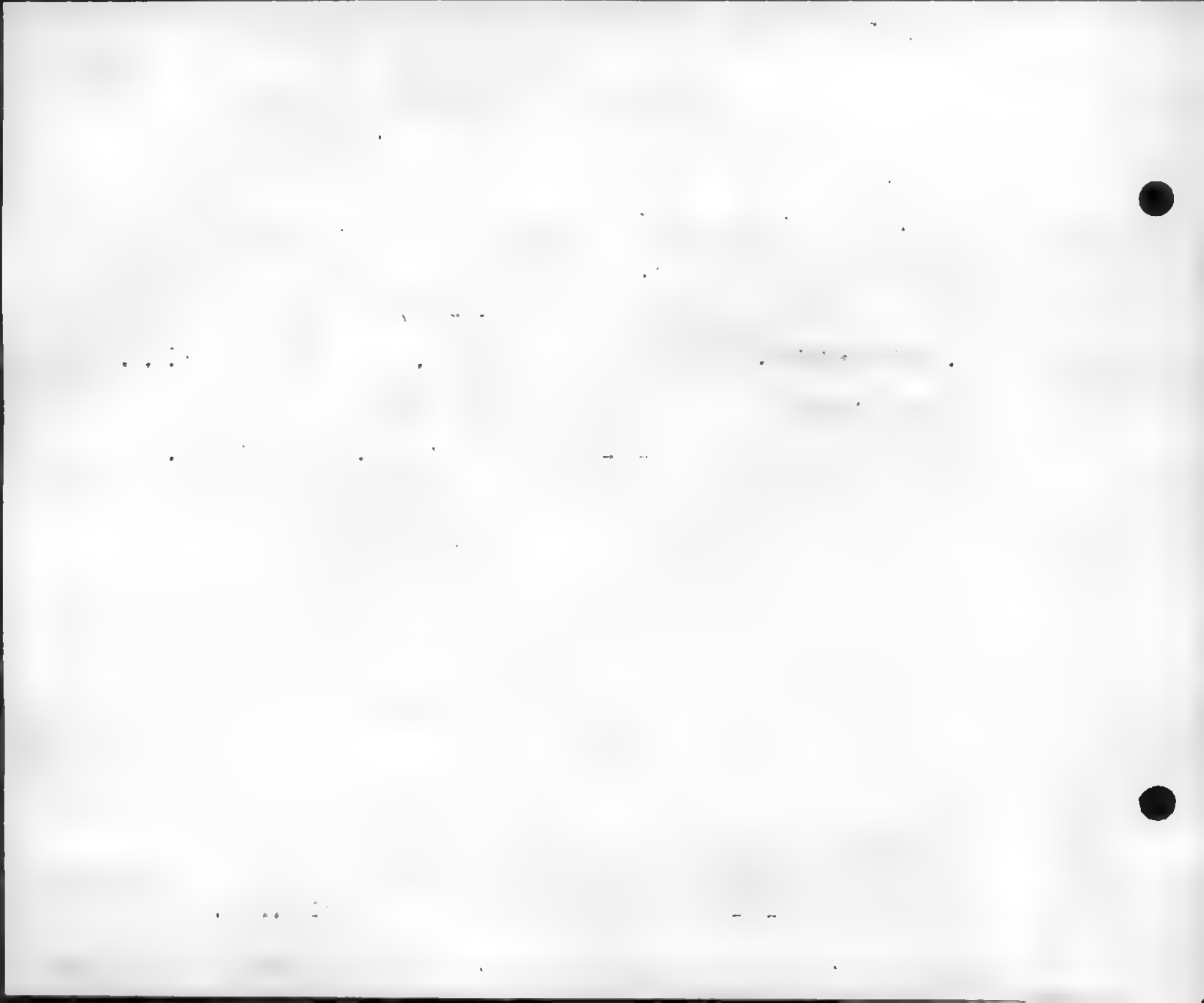
13565

13574

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>5715 Charlestowne</u>	
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>E.</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-91-</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of normal life, even if retired) <u>Ret. Employee Balto. City</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Julia Shea</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>220-09-4850</u>	
17. INFORMANT <u>Edward O'Brien, 105 Sipple Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Refractory anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 yrs.</u> <u>5 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>about</u> , 19 <u>60</u> , to <u>10-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-19</u> , 19 <u>67</u> , and that death occurred at <u>9 P.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Lawrence M. Serra</u>		22b. DATE SIGNED <u>10-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence M. Serra</u>		22d. ADDRESS <u>H. E. Chase St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13575

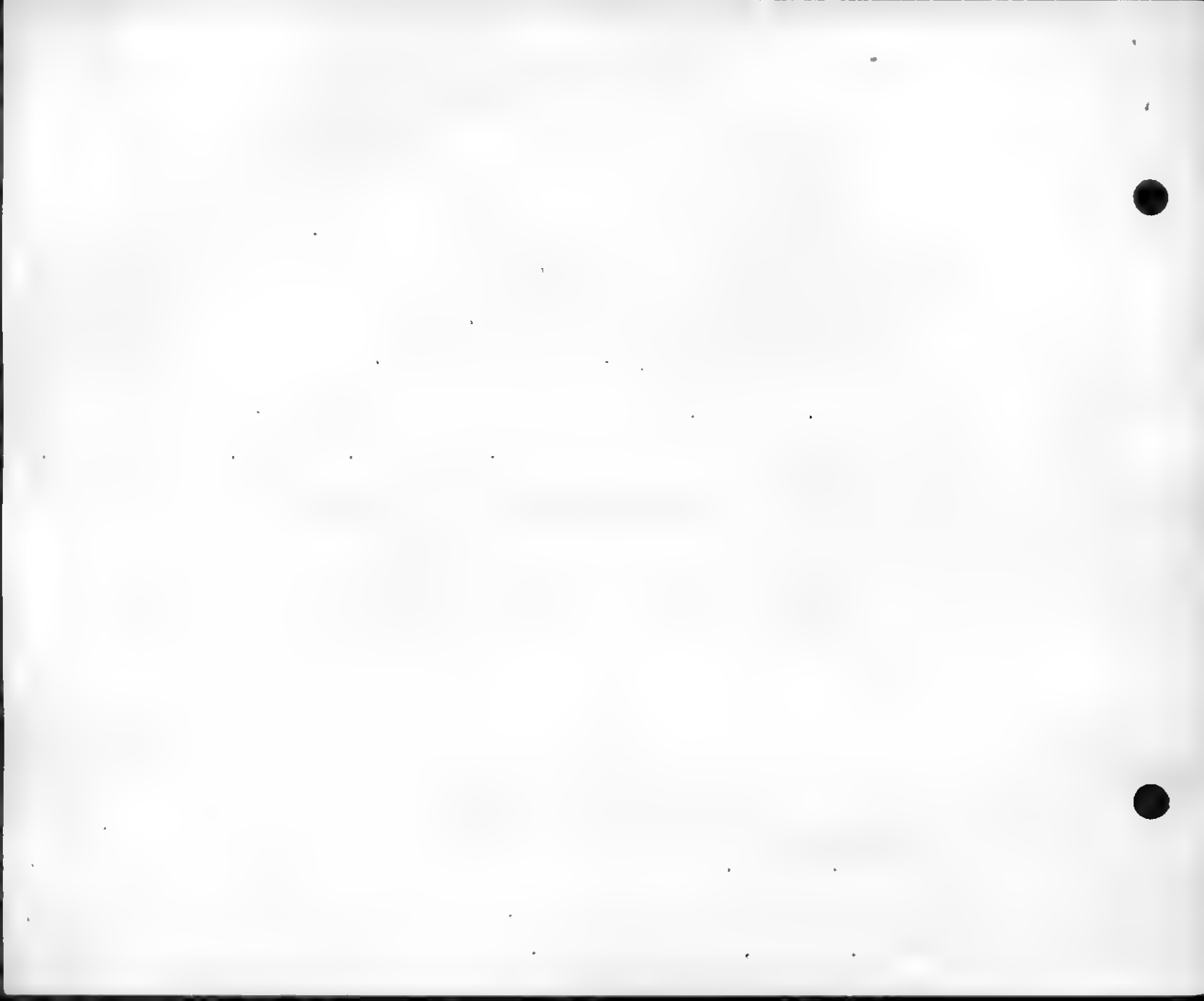
13569

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN 1b Lansdowne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 255 Clyde Ave.		d. STREET ADDRESS 255 Clyde Ave. 21227	
3. NAME OF DECEASED (Type or print) William Clifford Oden		4. DATE OF DEATH Month 10 Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SeP DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/33
9. AGE (In years last birthday) 33 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tolliver S. Oden, Sr.		14. MOTHER'S MAIDEN NAME Ida - - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 21227	
17. INFORMANT Mr. Tolliver S. Oden, Sr., 255 Clyde Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Strangulation by Hanging 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. James N. Frederick EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1311 Francis Ave.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 ADDRESS		25a. REC'D BY REGISTRAR OCT 25 1967 DATE	
25b. REGISTRAR'S SIGNATURE William Judge		22. DATE SIGNED 10/25/67	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Use Pages 1, 2, and 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13570

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13576

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b 3 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 328 Regester Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 328 Regester Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) First Charles Middle J. O'Hara Last 4. DATE OF DEATH Month Oct. Day 29 Year 1967		5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 10, 1907 9. AGE (n years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk 10b. KIND OF BUSINESS OR INDUSTRY Steel Co. 11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John T. O'Hara 14. MOTHER'S MAIDEN NAME Anna Bosson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 212-01-7921 17. INFORMANT Address Mrs. Josephine O'Hara same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Posterior Fossa Brain Tumor - probably Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma (c) Carcinoma Lung. (Metastasis July 67) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 1967, to August , 1967, that (I) (we) last saw the deceased alive on Aug-2 , 1967, and that death occurred at 2 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. Richard Ferguson 22c. PHYSICIAN'S NAME (Type) W. Richard Ferguson 22d. ADDRESS 1050 York Road 21204 Towson, MD		22b. DATE SIGNED Oct. 30 - 67 MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Nov. 2, 1967 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Will. Cook-Brooks Towson ADDRESS 1050 York Road 21204 Towson, MD 25a. REC'D BY REGISTRAR NOV 2 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undertaker, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

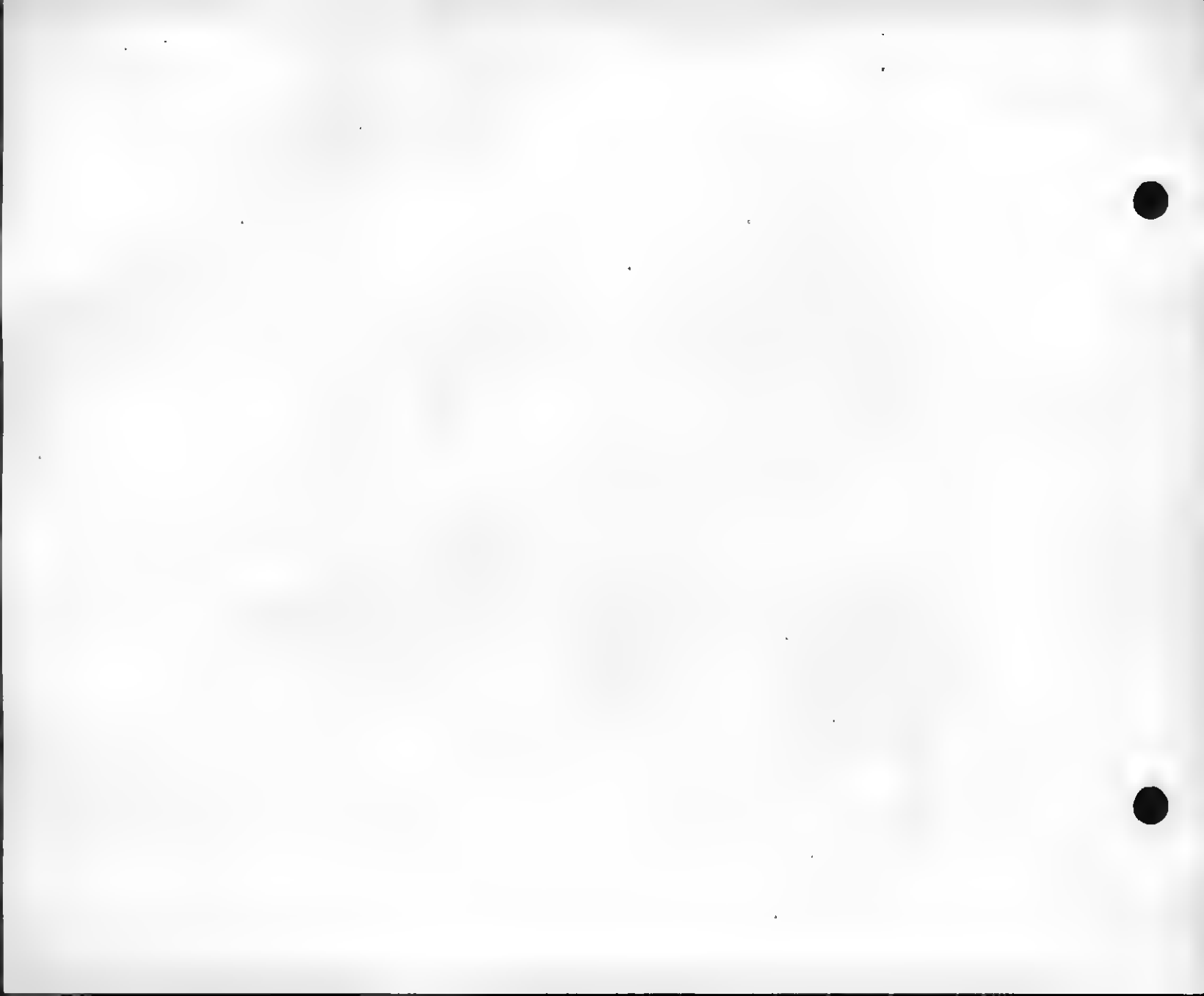
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13577A

CERTIFICATE OF DEATH

13577

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>279 Chatsworth Ave.</u>		d. STREET ADDRESS <u>279 Chatsworth Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>D.</u> Last <u>Owings</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1886</u>
9 AGE (In years last birthday) yrs <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Thomas Rawlings</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Cook</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>220-54-5530</u>	
17 INFORMANT <u>Mrs. M. Dorothea Miller</u>		Address <u>Reisterstown, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>& V.A. D. cerebral degeneration</u> (c) <u>terminal pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL/DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1-1-1930</u> to <u>10-20-1967</u> that (I) <u>was</u> last saw the deceased alive on <u>10-19-1967</u> , and that death occurred at <u>12 A</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>James G. Saffell</u>		22b DATE SIGNED <u>10-20-67</u>	
22c PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d ADDRESS <u>Reisterstown, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Oct. 23, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Reisterstown, Md.</u>
24 FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		ADDRESS <u>Reisterstown, Md.</u>	
25a REC'D BY REGISTRAR DATE <u>OCT 23 1967</u>		25b REGISTRAR'S SIGNATURE <u>John Charles Jones</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

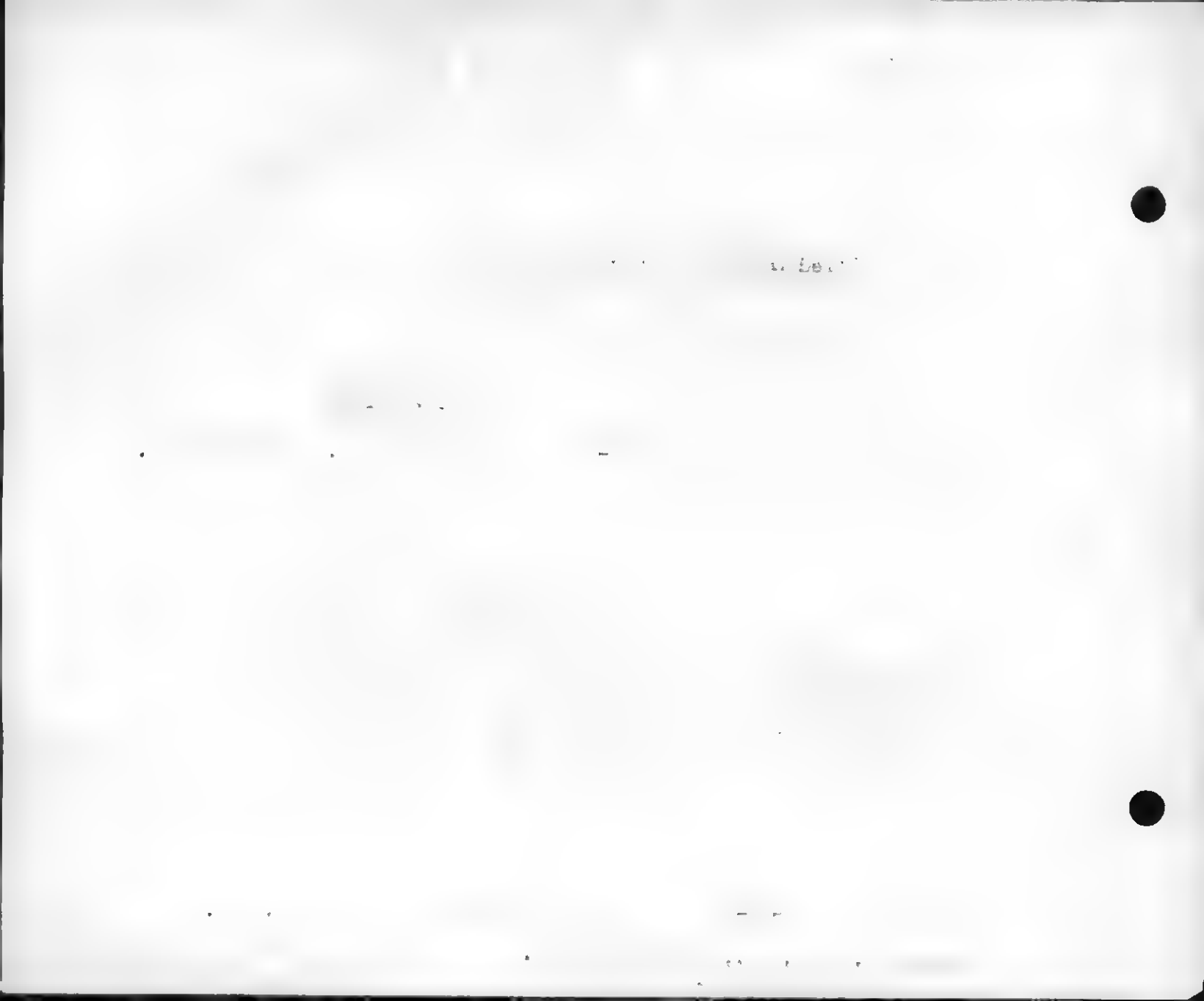
CERTIFICATE OF DEATH

13578

13572

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>Baltimore, Md 21215</u>	
3. NAME OF DECEASED (Type or print) First <u>Alfred (Alfonso)</u> Middle <u>Charles</u> Last <u>Palaski</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-10</u>
9. AGE (in years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Emerson Hotel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Palaski</u>		14. MOTHER'S MAIDEN NAME <u>Julia Bernos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-2817</u>	
17. INFORMANT <u>Angelina Palaski, 4512 Garden Dr.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Maligancy, Rt. Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>to brain metastasis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-26-66</u> , 19 <u>66</u> , to <u>10-18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-18</u> , 19 <u>67</u> , and that death occurred at <u>BALTIMORE</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Jose M. de Leon</u> M.D.		22b. DATE SIGNED <u>10-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-21-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

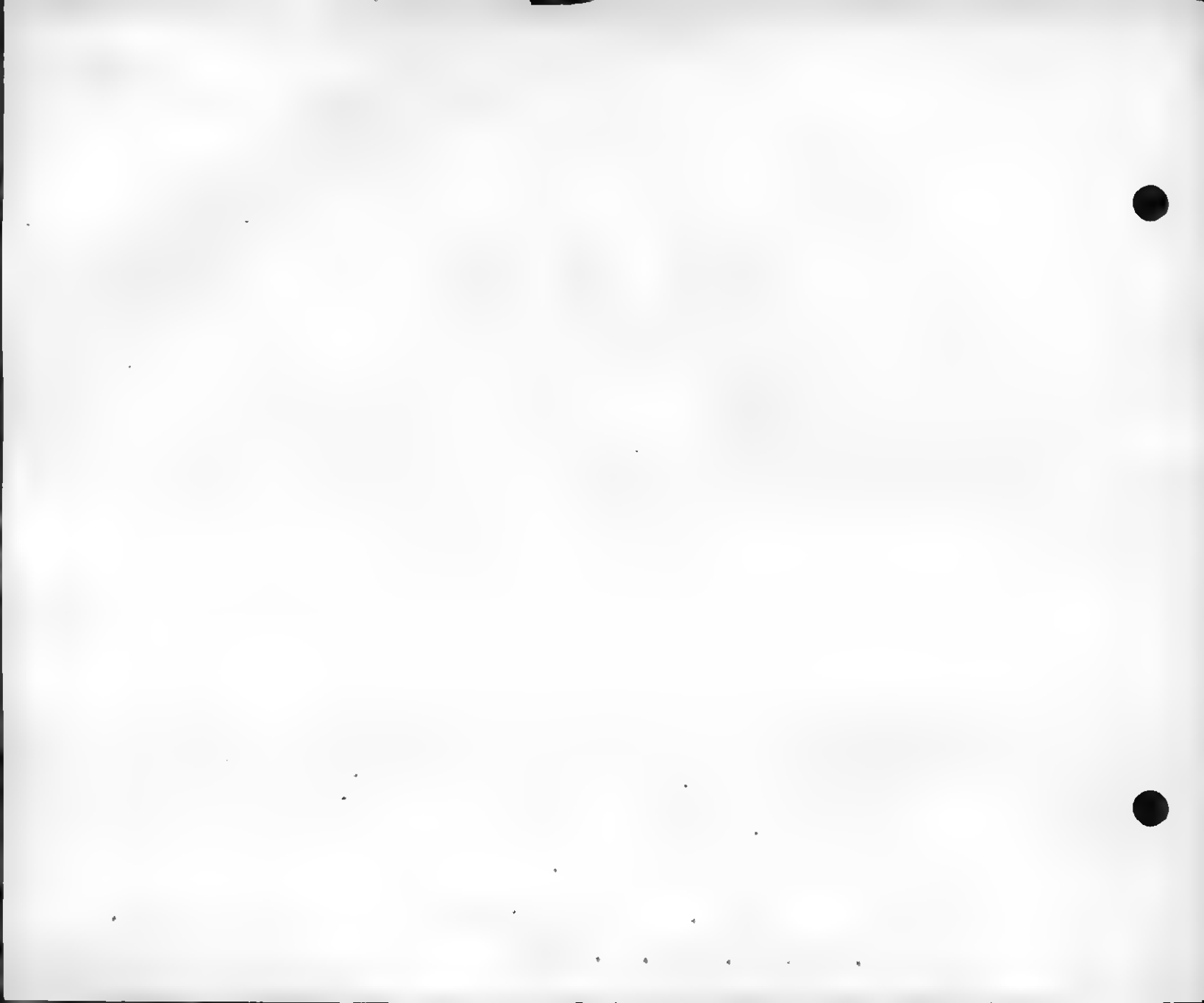
CERTIFICATE OF DEATH

13579

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23yr5mth9dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1819 North Milton Avenue	
3. NAME OF DECEASED (Type or print) First James Middle Lewis Last Parker		4. DATE OF DEATH Month October Day 24 Year 67	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 14, 1904
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not real) printer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Parker		14. MOTHER'S MAIDEN NAME Lydia Horst	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 212-07-1427	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular heart disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Arteriosclerosis, generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobar pneumonia, terminal; organism undetermined		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 15, 1944 , to Oct. 24, 1967 , that (X) (we) last saw the deceased alive on Oct. 24, 1967 , and that death occurred at 3:15 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young M.D.</i>		22b. DATE SIGNED 10-25-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/28/67.	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE OCT 26 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Young</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13580

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Randallstown, Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill Nursing Home</u>		d. STREET ADDRESS <u>5013 Westhills Road</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian I. Pearson</u>		4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1909</u>
9. AGE (in years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>Ella</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Delmas O. Pearson</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C.A. of Pancreas & Metastases</u> <u>157X</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-28-1967</u> , to <u>10-23-1967</u> , that (I) (we) last saw the deceased alive on <u>10-23-1967</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Cesar Valle Caverio</u>		22b. DATE SIGNED <u>10-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERIO</u>		22d. ADDRESS <u>8629 Liberty Rd</u>	
23a. BURIAL, CREMATION, or DISPOSAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Maryland</u>
24. FUNERAL DIRECTOR <u>Witzke & Sons 4101 Edmondson Ave. 21229</u>		25a. REC'D BY REGISTRAR <u>DATE 11 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20M 1/65

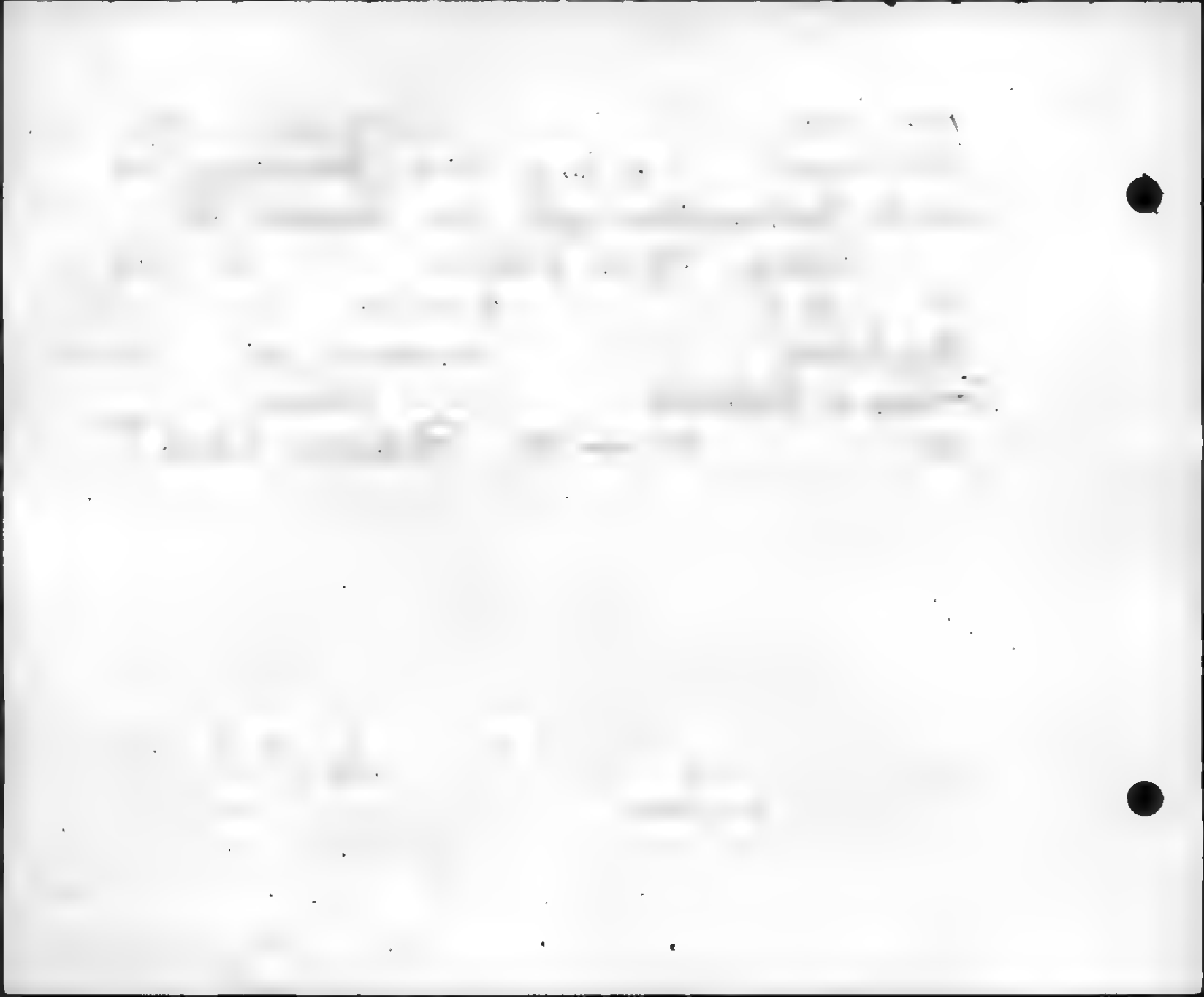
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

23575

13581

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3500 Rosedale Rd</u> d. STREET ADDRESS <u>3500 Rosedale Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>George HARRIS Pendheton</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1967</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-29-01</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis, Md</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George L. Pendheton</u>				14. MOTHER'S MAIDEN NAME <u>Clarina HARRIS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. <u>214-44-7119</u>				17. INFORMANT <u>Patient's CHART</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO (b) <u>Post Pneumonecctomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>carcinoma Right lung</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>10-5-</u> , 19 <u>67</u> , to <u>10-24-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-24-</u> , 19 <u>67</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above.												22b. DATE SIGNED <u>10-24-67</u>	
22a. SIGNATURE <u>P. Chaudhuri</u>				22c. PHYSICIAN'S NAME (Type) <u>P. CHAUDHURI</u>				22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Annapolis Md. Anne Arundel Co.</u>					
24. FUNERAL DIRECTOR <u>Herbert E. Nutter-3035 W. North Ave.</u>				25a. REC'D BY REGISTRAR <u>OCT 21 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD

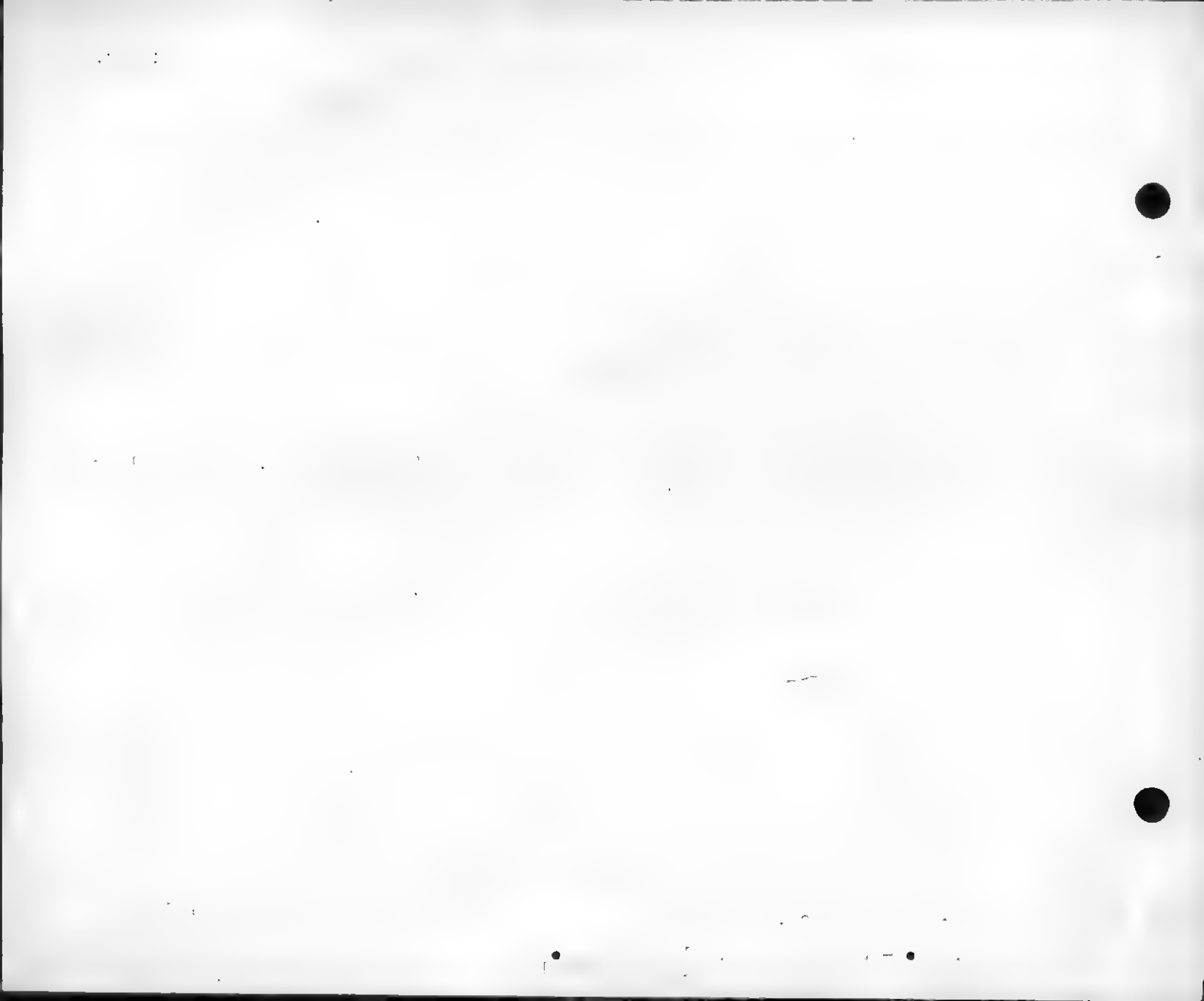
13573

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13582

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MASS.</u> b. COUNTY <u>J</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY in 1b <u>14</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NARRAGANSETT AVE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Masonic Homes BonnieBlink</u>				d. STREET ADDRESS <u>Pittsfield</u>		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>E</u> Last <u>Perine</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/1875</u>	9. AGE (In years last birthday) <u>92</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hall</u>				14. MOTHER'S MAIDEN NAME <u>Louise M. Powell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-16-04568</u>		17. INFORMANT <u>Masonic Home, Cockeysville, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Monocytic Leukemia</u> DUE TO <u>3 Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Brain Syndrome</u> (c) <u>General arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1965</u> to <u>8930</u> , 1967 that (I) (we) last saw the deceased alive on <u>8930</u> 1967, and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>JAMSHID HAMED, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED</u>				22d. ADDRESS <u>MASONIC HOME</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson,</u>				ADDRESS <u>1050 York Road Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 5 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

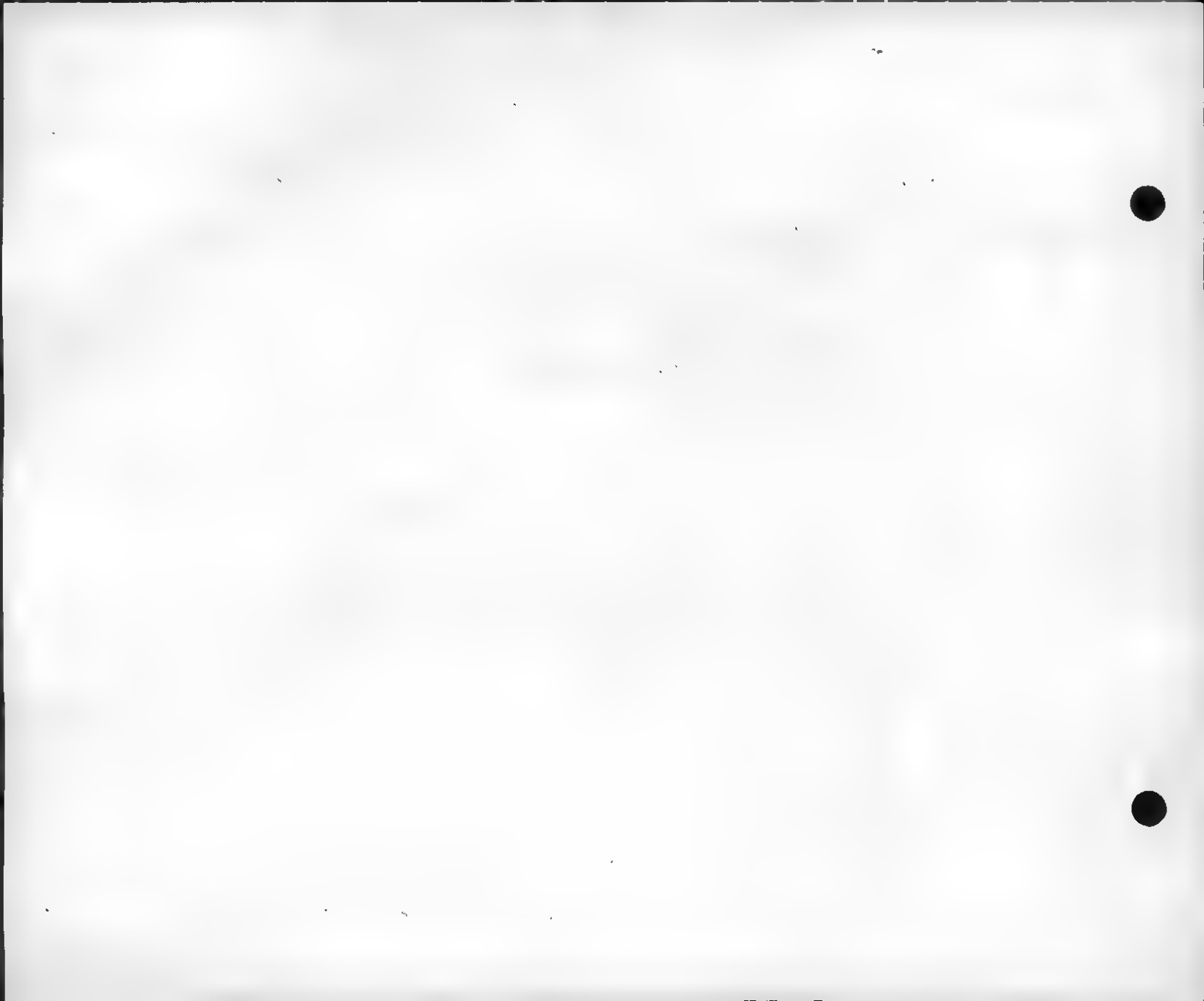
CERTIFICATE OF DEATH

13583

13573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson			c. LENGTH OF STAY in 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS 1661 SALEM AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle RANDOLPH Last PERROTT				4. DATE OF DEATH Month 10 Day 28 Year 1967			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-2-06		9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apprentice Serviceman		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store		11. BIRTHPLACE (County & State or foreign country) CHARLTON, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB PERROTT				14. MOTHER'S MAIDEN NAME EFFIE BERTELS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-09-8894		17. INFORMANT Records at Mount Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 3, 1967 , to OCT. 28, 1967 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 12:50 PM , from causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/31/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
24. FUNERAL DIRECTOR Paul H. Hargrave				24a. ADDRESS 1661 Salem Ave.		24b. REGISTRAR'S SIGNATURE Charles Jones	
25a. REC'D BY REGISTRAR OCT 31 1967				25b. REGISTRAR'S SIGNATURE Charles Jones			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #7 Film #3393 16/19/67 ph
CERTIFICATE OF DEATH

13584

13578

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>03</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>521 Sussex Road</u>		d. STREET ADDRESS <u>521 Sussex Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Charlotte</u> Last <u>Perry</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1904</u>
9. AGE (In years last birthday) <u>63</u> yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk & just retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. County</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George A. Ooden</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Brant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO <u>220-12-7578</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm of Ascending Aorta</u> 442X DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1966</u> to <u>October 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 15, 1966</u> and that death occurred at <u>4:24</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. O'Donnell</u>		22b. DATE SIGNED <u>10-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		22d. ADDRESS <u>M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>10-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Towson, Md.</u>
24. FUNERAL DIRECTOR <u>John Burns Sons</u>		25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>	
ADDRESS <u>Towson, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

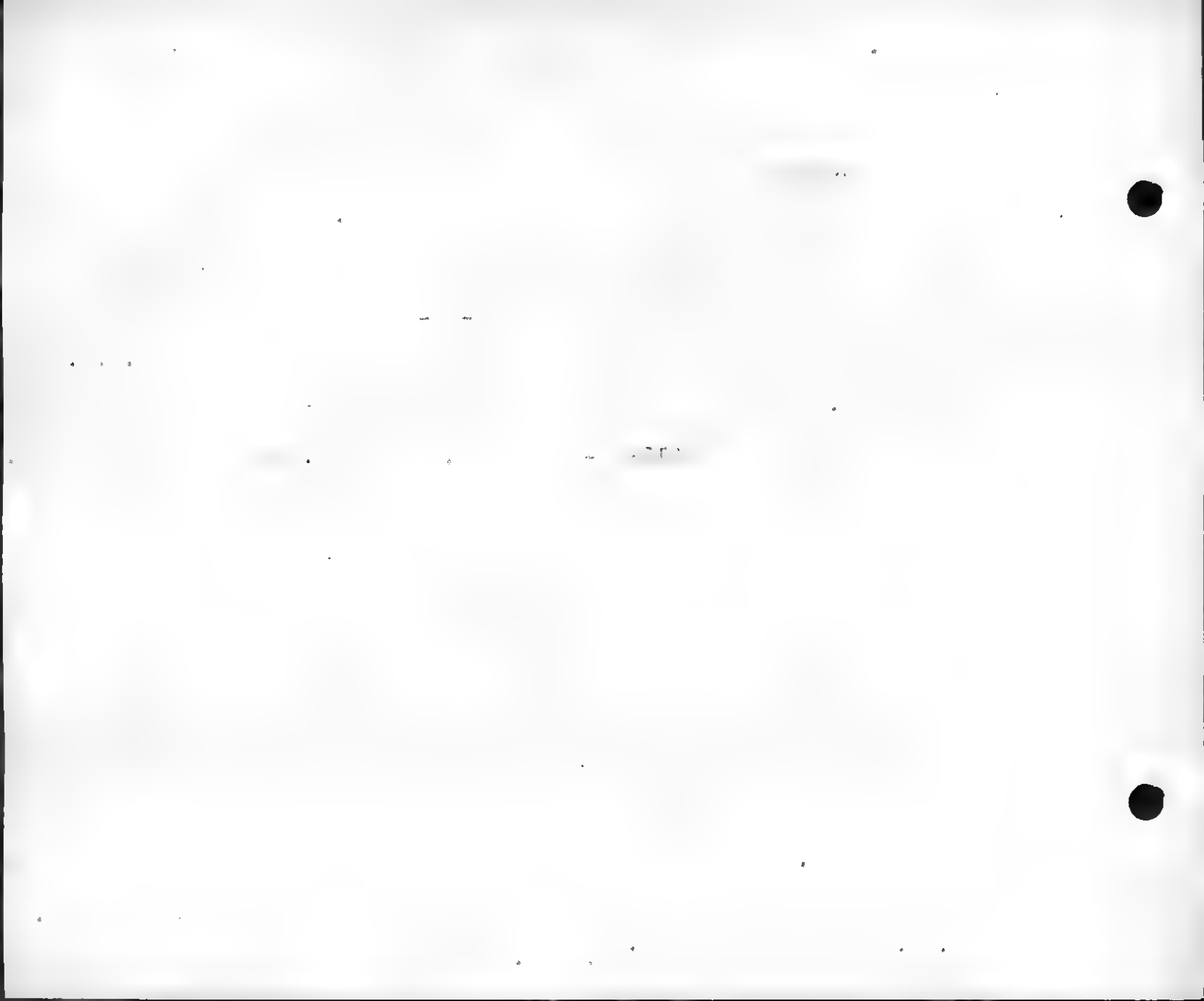
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Roland Ave. & Rectory Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marguerite Easter Peterson			4. DATE OF DEATH Month Day Year 10- 17 1967				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1883	9. AGE (In years last birthday) 83 yrs	10. UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James W. Easter				
14. MOTHER'S MAIDEN NAME Marguerite Miller			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO 213-09-1888		17. INFORMANT Address Owings, Mills Mrs. George P. Ward 2117 Valley Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of breast - metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 4 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, arteriosclerotic heart disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (1) (this hospital) attended the deceased from <u>Sept 16, 1967</u> to <u>Oct 17, 1967</u>, that (1) was lost the deceased alive on <u>16 Oct</u> 1967, and that death occurred at <u>2A</u> M, from causes and on the date stated above.							
22a. SIGNATURE Paul H Royce			22b. DATE SIGNED 17 Oct 1967		22c. PHYSICIAN'S NAME (Type) Dr. Paul Royce		
22d. ADDRESS 1403 Foley Lane Pikesville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 10-19-67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.			
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co			25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13530

135306

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY BALTO. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 125 FOREST DRIVE
2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Md. b. COUNTY BALTO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE
d. STREET ADDRESS 125 FOREST DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) CARRIE GREY PHILLIPS First Middle Last
4. DATE OF DEATH OCT 10 1967 Month Day Year
5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 4/24/92 9. AGE (In years last birthday) 75 Yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARM. 10b. KIND OF BUSINESS OR INDUSTRY RET. 11. BIRTHPLACE (County & State, or foreign country) PA. 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME GEORGE W. MESSOP 14. MOTHER'S MAIDEN NAME SADIE BLUMENTHAL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO 17. INFORMANT MRS. NELVA C. ACKMAN Address
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia 3 days
DUE TO Generalized Adeno Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO General Metastasis
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While ☐ Not While ☐ at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1967 to Oct 10 1967, that (I) (we) last saw the deceased alive on Oct 10 1967, and that death occurred at 8:00 AM, from causes and on the date stated above.
22a. SIGNATURE Wetherbee Fort M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Wetherbee Fort 22d. ADDRESS 6 Sutton Ave. Balto. 21215
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 10/13/67 23c. NAME OF CEMETERY OR CREMATORY LONDON PARK 23d. LOCATION (City or Town) (County) (State) BALTO MD.
24. FUNERAL DIRECTOR E.S. MACNAB 301 FREEDMAN RD 21228 ADDRESS
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DATE OCT 16 1967

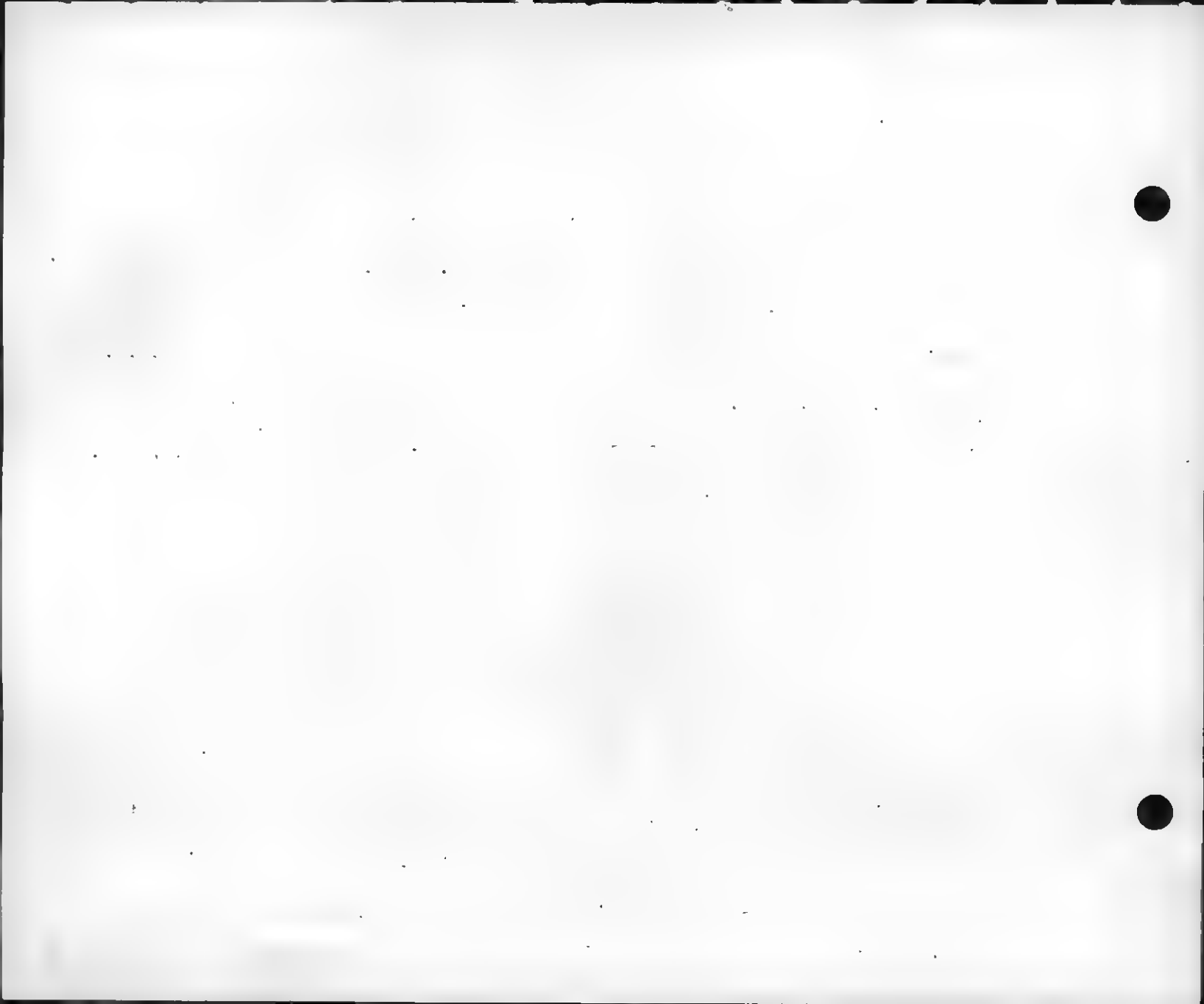


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER						d. STREET ADDRESS Sherwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM BRAND PINDELL Jr.			4. DATE OF DEATH Month Day Year 10 17 19 67			5. SEX Male		6. COLOR OR RACE Cauc.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1910		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXX Clerk			10b. KIND OF BUSINESS OR INDUSTRY Dairy			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William B. Pindell Sr.					14. MOTHER'S MAIDEN NAME Emily Buck				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 213-12-4821		17. INFORMANT David Lee Pindell			Address Western Run Road Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/16 1967, to 10/17 1967, that (I) (we) last saw the deceased alive on 10/17 1967, and that death occurred at 3:07 a M, from the causes and on the date stated above.									
22a. SIGNATURE John E. Adams						22b. DATE SIGNED 10/17/67		22c. PHYSICIAN'S NAME (Type) John E. Adams, M. D.	
22d. ADDRESS Greater Baltimore Medical Center									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1967		23c. NAME OF CEMETERY OR CREMATORY Dread Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pikesville, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road 21204		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE OCT 18 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN b 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. STREET ADDRESS 27 Rosewood Lane	
3 NAME OF DECEASED (Type or print) EDWARD First JAMES Middle POE Last		4. DATE OF DEATH Month 10 Day 29 Year 19 67	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.9. 1900
9 AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 6 Days 29 Hours 19 Min 67	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELI POE		14. MOTHER'S MARDEN NAME ANNA AMBROSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-09-9081	
17. INFORMANT Records at Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA & CONGESTION DUE TO BRONCHITIS, CHRONIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA of HYPOPHARYNX; PULM. EMPHYSEMA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10.12. 19 67 to 10.29. 19 67 that (I) (we) last saw the deceased alive on 10.29. 19 67 , and that death occurred at 4:15 M. from causes and on the date stated above.			
22a. SIGNATURE William Newcomer		22b. DATE SIGNED 10.29.1967	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
Burial	Nov. 2, 1967	Woodlawn Cemetery	Woodlawn, Maryland
24. FUNERAL DIRECTOR A. J. Schuchardt		25a. REGISTERED BY REGISTRAR NOV 3 1967	
ADDRESS Owings Mills, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

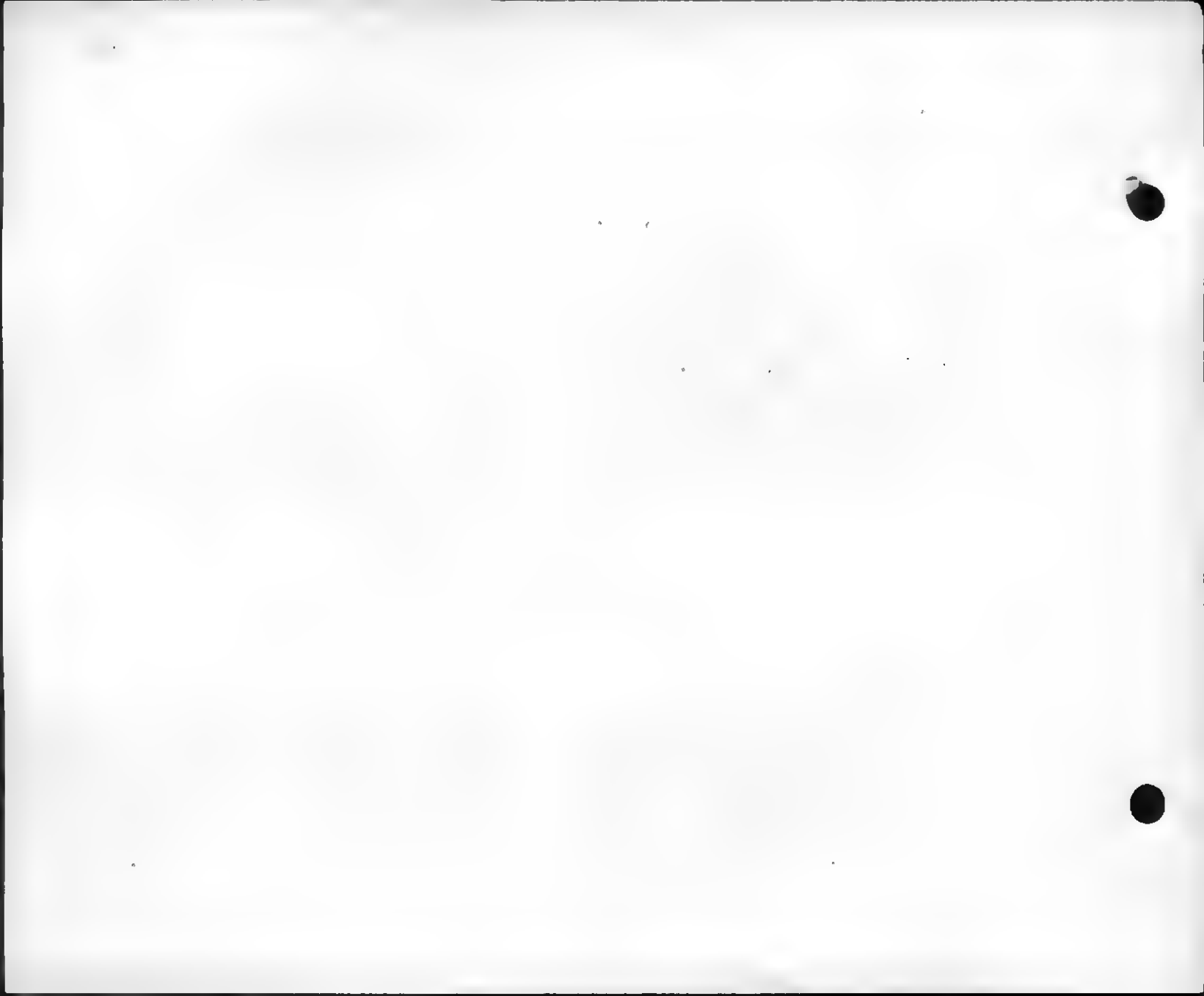
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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204		STREET ADDRESS 207 Donnybrook Lane, 21204	
3. NAME OF DECEASED (Type or print) First William Middle Montgomery Last POMEROY		4. DATE OF DEATH Month October Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-84
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZENSHIP OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert J. Pomeroy	
14. MOTHER'S MAIDEN NAME Louise Beatty		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO 220 44 6381		17. INFORMANT Della Pettie Address 207 Donnybrook Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Infarction DUE TO (b) Pulmonary Thromboembolism DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-20 , 19 67 , to 10-14 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-14 , 19 67 , and that death occurred at 2:20 PM from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 10-14-67	
22c. PHYSICIAN'S NAME (Type) Dr. Reynaldo Orjuela-Gomez		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-17-67	23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK Cem	23d. LOCATION (City or Town) (County) (State) Woodlawn Balto Md
24. FUNERAL DIRECTOR Burges Funeral Home 3631 Falls Rd Balto		25a. REC'D BY REGISTRAR DATE OCT 17 1967	25b. REGISTRAR'S SIGNATURE J. L. Jones



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners' Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13580

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CASEX</u>		c. LENGTH OF STAY IN 1b <u>Baltimore 21221</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>618 S. Marilyn Avenue</u>		e. STREET ADDRESS <u>618 S. Marilyn Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>K.</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 3, 1903</u>
9 AGE (In years last birthday) <u>64</u> yrs		10 IF LINDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Henry J. Kyle</u>		14 MOTHER'S MAIDEN NAME <u>Sally J. Walker</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>233-72-4201</u>	
17 INFORMANT <u>Mr. David J. Price</u>		Address <u>(Same)</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>413x</u> DUE TO (b) <u>Hyperleusis Cardiovascular</u> DUE TO (c) <u>Research</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ca of ulcers</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>pm</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo C. Patterson</u> M.D.		22. DATE SIGNED <u>10/9/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Salem Virginia.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto, Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13591

12583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>523 Allegheny Avenue</u>		d. STREET ADDRESS <u>523 Allegheny Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Boyd</u> Last <u>Raphel</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1889</u>
9. AGE (in years last birthday) <u>78</u> yrs.		10. UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Taylor Boyd</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Dobbshell Darnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>62</u> to <u>10/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>67</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence C. Post</u>		22b. DATE SIGNED <u>10/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C Post</u>		22d. ADDRESS <u>6805 York Rd - Balto 2112</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REG. STRA. DATE <u>6616 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13586

CERTIFICATE OF DEATH

13592

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 717 S. Glover Street	
3. NAME OF DECEASED (Type or print) First John Middle Reich Last Reich		4. DATE OF DEATH Month 10 Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-02
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months 0 Days 28 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Can	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Reich		14. MOTHER'S MAIDEN NAME Anna Krug	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-4928	
17. INFORMANT Mrs. Mary E. Reich,		Address 717 S. Glover St. Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO Arteriosclerotic cardiovascular disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH 21 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-8-1927 to 10-21-1967 , that (I) (we) last saw the deceased alive on 10-21-1967 , and that death occurred AVE A M , from causes and on the date stated above.			
22a. SIGNATURE John J. Gould		22b. DATE SIGNED 10-30-67	
22c. PHYSICIAN'S NAME (Type) John J. Gould		22d. ADDRESS 14th. EAST AVE. 21224	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/31/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Ave. Baltimore, Md.		25a. RECD BY REGISTRAR NOV 1 1967	
		25b. REGISTRAR'S SIGNATURE John J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13587

13593

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u> <u>MD</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>818 Kingston Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>818 Kingston Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Angela</u> Last <u>Reilly</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5 - 1877</u>	9. AGE (In years last birthday) <u>90</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>William P. Reilly</u>				
14. MOTHER'S MAIDEN NAME <u>Mary Byrne</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO <u> </u>			17. INFORMANT <u>Family Records</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>1530</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>of Lung & Liver</u> c) <u>Carcinoma of Lung & Liver</u> <u>Ascending</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 Month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>45</u> , to <u>10/24</u> , 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>10/22</u> 19 <u>67</u> , and that death occurred at <u>9:14</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Charles F O'Donnell</u> MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>10-24-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Charles F O'Donnell</u>			22d. ADDRESS <u>2501 York Rd</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-26-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR <u>Chas. T. Evans & Son</u>			ADDRESS <u>8802 Hartford Rd</u>		25a. RECD BY REGISTRAR DATE <u>OCT 26 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3588
 CERTIFICATE OF DEATH

13584

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>md.</u> b COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Marriottsville</u>		c LENGTH OF STAY IN 1b <u>Life</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Marriottsville</u>		d STREET ADDRESS <u>WARDS Chapel Road</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WARDS Chapel Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Reisberg</u> Last <u>Reisberg</u>		4 DATE OF DEATH Month <u>Oct.</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-6-1892</u>
9 AGE (In years last birthday) <u>75</u> yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Anton Reisberg</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Stockdale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>218-14-7598</u>	
17. INFORMANT <u>Mrs. Edna Reisberg - Marriottsville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 441 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A S C.V.D.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1965</u> , to <u>10/13</u> , 19 <u>67</u> that (1) (we) last saw the deceased alive on <u>10/12</u> , 19 <u>67</u> , and that death occurred at <u>2 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. J. Ellis</u>		22b. DATE SIGNED <u>10/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. J. Ellis, M.D.</u>		22d. ADDRESS <u>Randallstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WARDS Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Oct 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



FOR-STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Live pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12588

13595

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 Dunmore Rd</u>		d. STREET ADDRESS <u>24 Dunmore Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Doory</u> Last <u>Resau</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Ship research Center</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>Walter A. resau</u>		14. MOTHER'S MAIDEN NAME <u>Anna Marie DeMinnis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218 76 0004</u>	
17. INFORMANT <u>Mrs. Mary Resau</u>		Address <u>24 Dunmore Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. N. Frederick</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. N. Frederick MD</u>		Address (Street, city, town, or county) <u>1311 Francis Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 13 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Com.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore MD</u>
24. FUNERAL DIRECTOR <u>Farley Cavanaugh Funeral Home</u>		25a. REC'D BY REGISTRAR <u>2601 Frederick Ave.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

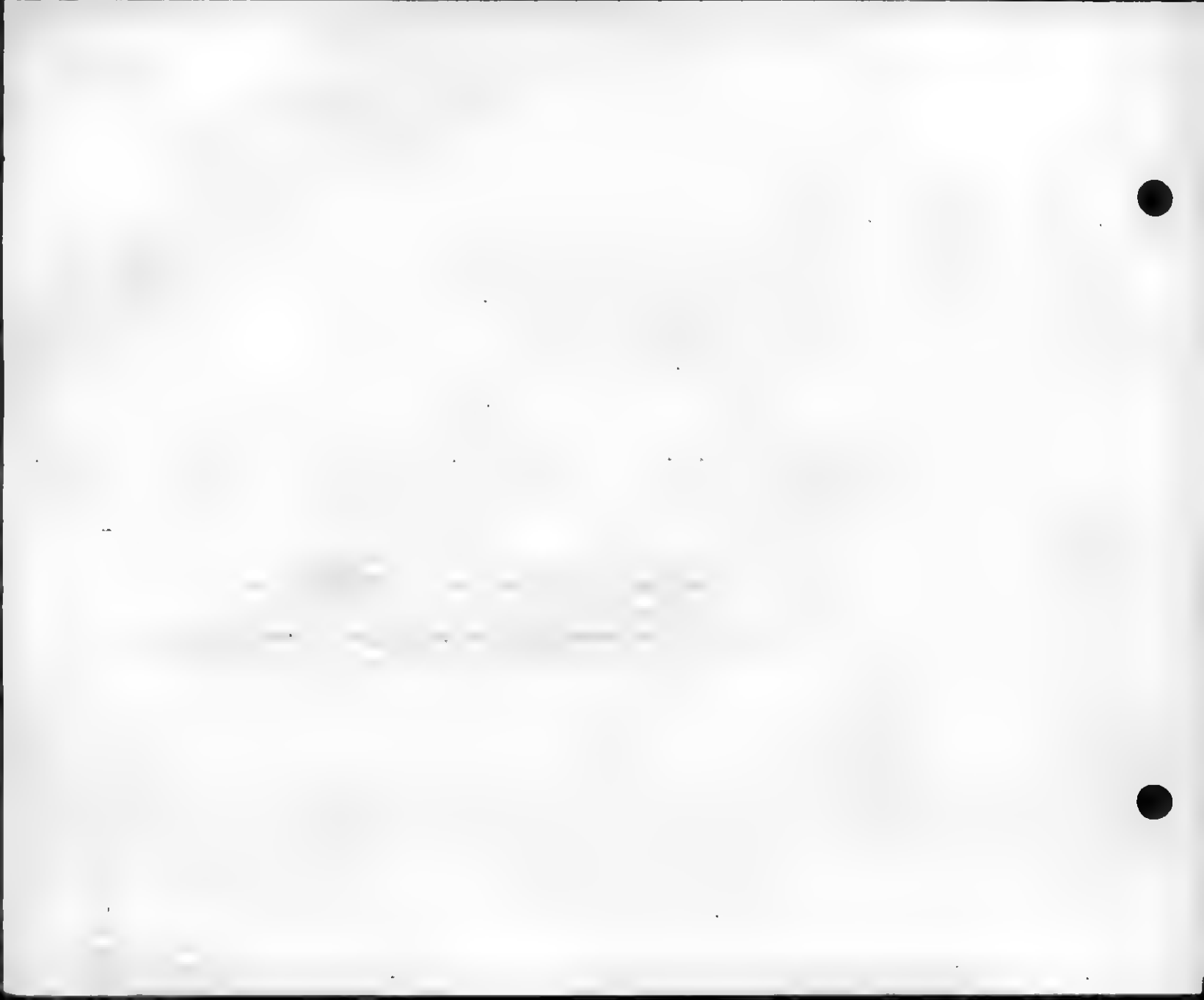
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13596

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital		e. STREET ADDRESS 8407 Liberty Road	
3. NAME OF DECEASED (Type or print) James V. Reynolds		4. DATE OF DEATH 10 30 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-98
9. AGE (In years last birthday) 69 yrs		10. UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		12. KIND OF BUSINESS OR INDUSTRY Bedrock Rubber Co	
13. BIRTHPLACE (County & State, or foreign country) Missouri		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Mark E. Reynolds		16. MOTHER'S MAIDEN NAME Maude Greever	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO 215-03-3773	
19. INFORMANT Mrs E. Ruth Reynolds		20. ADDRESS 8407 Liberty Rd Baltimore 7 Md	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Myocardial Infarction DUE TO Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY - Myocardial insufficiency (c) Severe Diffuse pulmonary edema & chronic passive congestion		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-28 , 19 67 , to 10-30 , 19 67 That (I) (we) last saw the deceased alive on 10-30 19 67 , and that death occurred at 9:30 M, from causes and on the date stated above			
22a. SIGNATURE ANGELA DPAAS		22b. DATE SIGNED 10-30 67	
22c. PHYSICIAN'S NAME (Type) ANGELA DPAAS		22d. ADDRESS BCHA	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md	
24. FUNERAL DIRECTOR Foringio		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13591

13597

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Overlea c. LENGTH OF STAY IN TB Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7214 Linden Ave				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Overlea d. STREET ADDRESS 7214 Linden Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Anna First Mariah Middle Rhodes Last		4. DATE OF DEATH October 10 Month 1967 Year		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 18, 1891 9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Rev. William Morman				14. MOTHER'S MAIDEN NAME Millie ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 115-12-10000				17. INFORMANT Mr. Luther E. Rhodes Address 7214 Linden Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular stroke accident DUE TO (b) Hypertension (c) Arteriosclerotic vascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) several years																INTERVAL BETWEEN ONSET AND DEATH 5 min.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Maryland		(State) Md.		21. I certify that (I) (this hospital) attended the deceased from 8:31 1967 to 10:10 1967 , that (I) (we) last saw the deceased alive on 9-2 1967 , and that death occurred at 10 A.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED 10-10-67		22c. PHYSICIAN'S NAME (Type) Richard R. Rigler, M.D.		22d. ADDRESS 1 W. Overlea Ave. Balto, Md. 2120		22e. REC'D BY REGISTRAR OCT 19 1967		22f. REGISTRAR'S SIGNATURE <i>[Signature]</i>		22g. DATE OCT 19 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland		23e. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery		23f. LOCATION (City, town or county) Baltimore, Maryland		23g. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery					
24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter				24b. ADDRESS 3035 W. North Ave		24c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery		24d. LOCATION (City, town or county) Baltimore, Maryland		24e. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery		24f. LOCATION (City, town or county) Baltimore, Maryland		24g. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery					



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

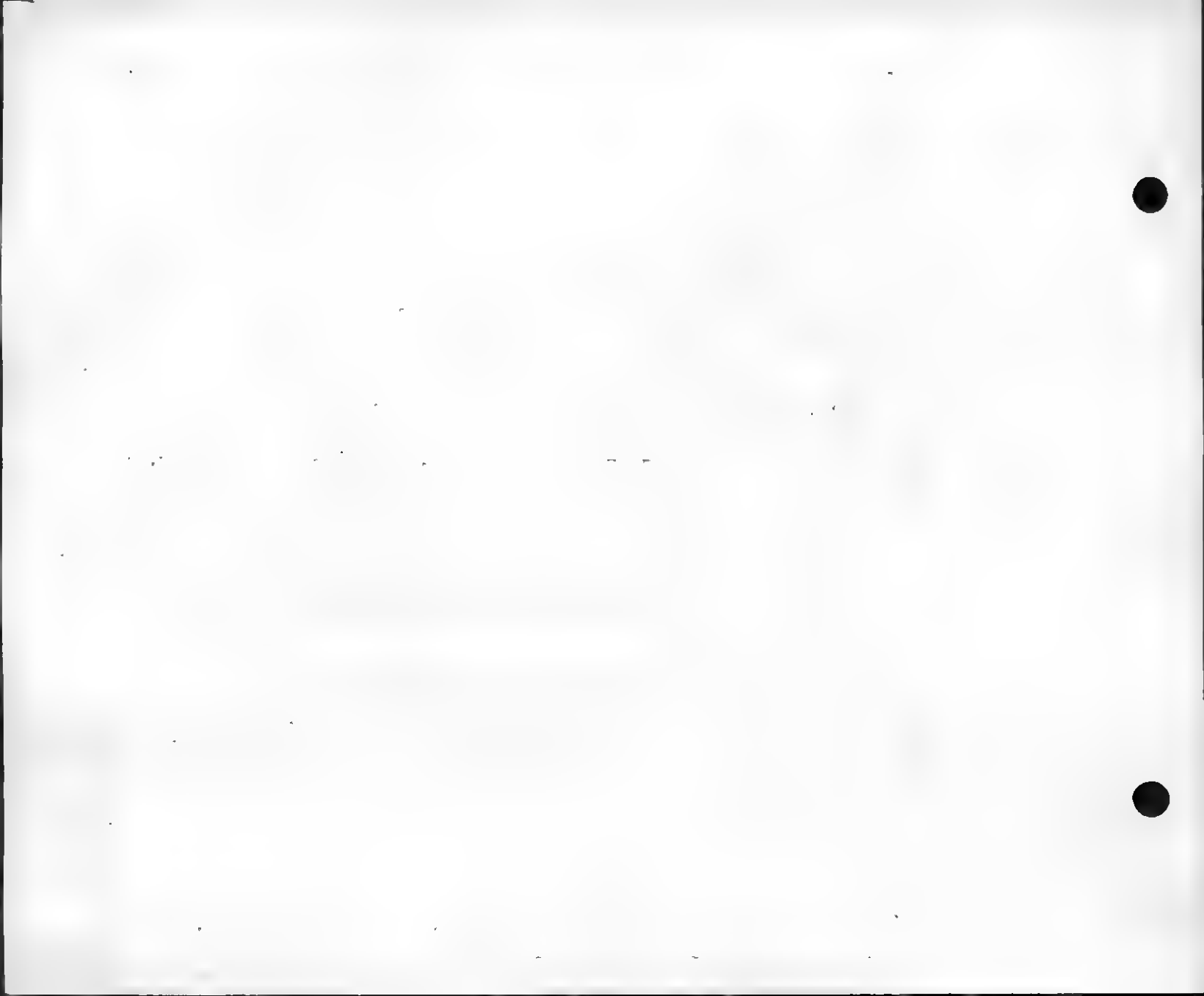
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13598

1 PLACE OF DEATH a COUNTY Baltimore 21204 MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Maryland b COUNTY _____	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b Baltimore 21212	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d STREET ADDRESS 504 Castle Drive	
3 NAME OF DECEASED (Type or print) First Ethel Middle Isabelle Last Ricker		4 DATE OF DEATH October 7 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 12, 1887
9 AGE (in years last birthday) 79 yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Drug Dept.	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S. A.	
13 FATHER'S NAME Chas. Ricker		14 MOTHER'S MAIDEN NAME Agnes Galloaway	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO 216-28-9748A	
17 INFORMANT Mr. Geo. Cristie-504 Castle Dr. 21212		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Internal Hemorrhage & Fracture 7 Days DUE TO (c) CC belt & Hip Pulses & Leg PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck by Automobile			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY (a) OR CONTRIBUTING (b) CAUSE OF DEATH Struck by Automobile		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by Automobile	
20c TIME OF INJURY Month, Day, Year 12:30 a.m. 9/30 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.) Street		20f CITY OR TOWN (County) (State) Baltimore City MD.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county) 107/67	
22a BURIAL, CREMATION REMOVAL (Specify) Burial	22b DATE THEREOF 10/10/67	22c NAME OF CEMETERY OR REMATORY Prospect Hill Cem.	22d LOCATION (City or town) (County) (State) Towson, Md.
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd-21212		25a REL'D BY REGISTRAR OCT 11 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13593

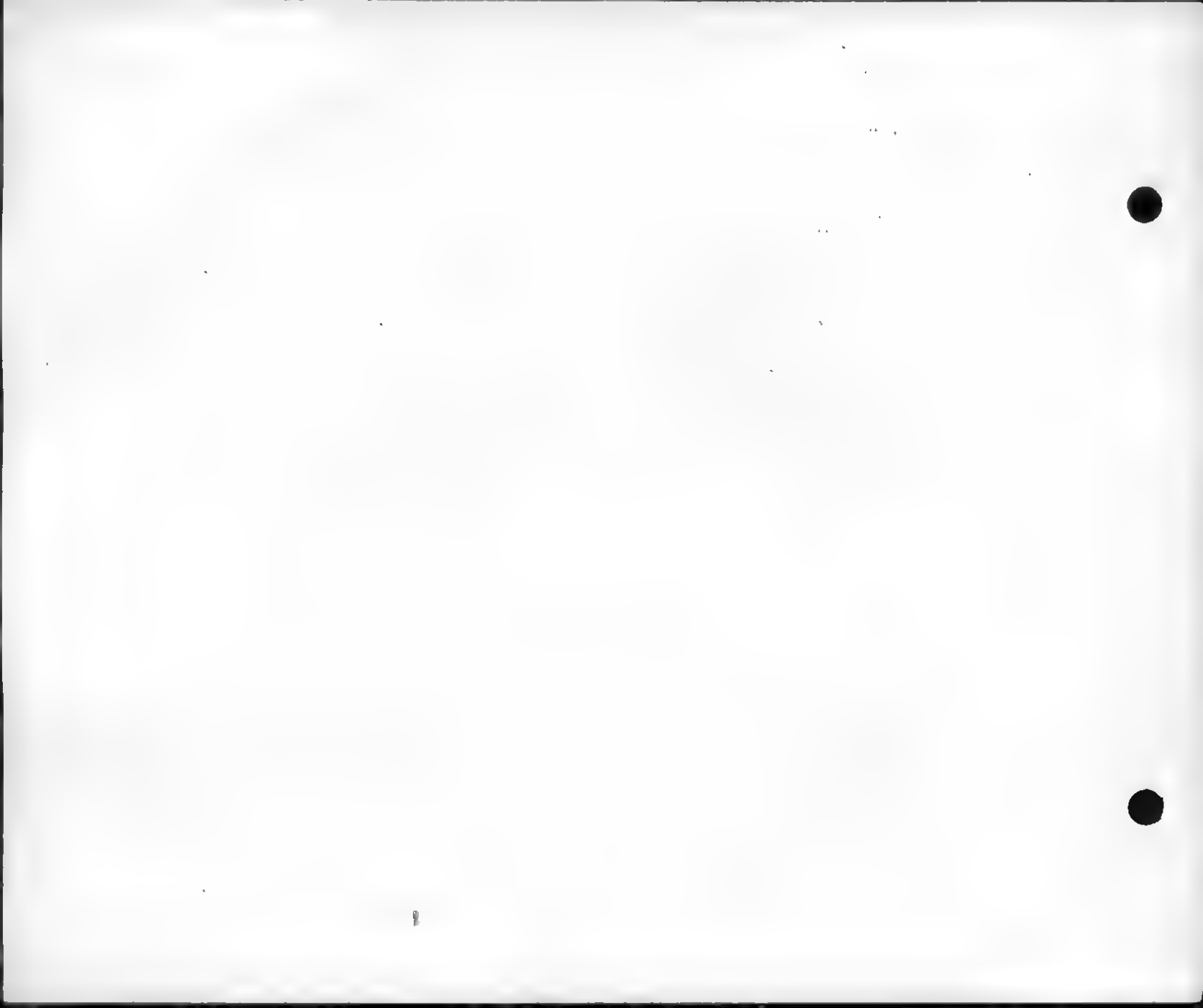
13599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson c. LENGTH OF STAY IN b 48 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4932 Park Heights Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ralph First Robinson Middle Robinson Last 5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 2.28.1892 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.		4 DATE OF DEATH 10 12 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rivet Clerk Racetrack 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) Baltimore Md. 12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Martin Robinson 14. MOTHER'S MAIDEN NAME Emma Funk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO 265-01-9538 17. INFORMANT Records, Mt. Wilson State Hospital Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last tuberculosis DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease.		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 8.25 , 19 67 , to 10.12 , 19 67 , that (I) (we) last saw the deceased alive on 10.12 , 19 67 , and that death occurred at 2.40 M, from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIR. <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10.12.1967		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. 22d. ADDRESS Mt. Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) buried 23b. DATE THEREOF Oct 11, 1967 23c. NAME OF CEMETERY OR PREMATORY St. Ambrose 23d. LOCATION (City or town) (County) (State) BALTIMORE Md.		24. FUNERAL DIRECTOR Frank H. Jewell ADDRESS W. Jewell, Baltimore Md. 25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge	

OCT 13 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

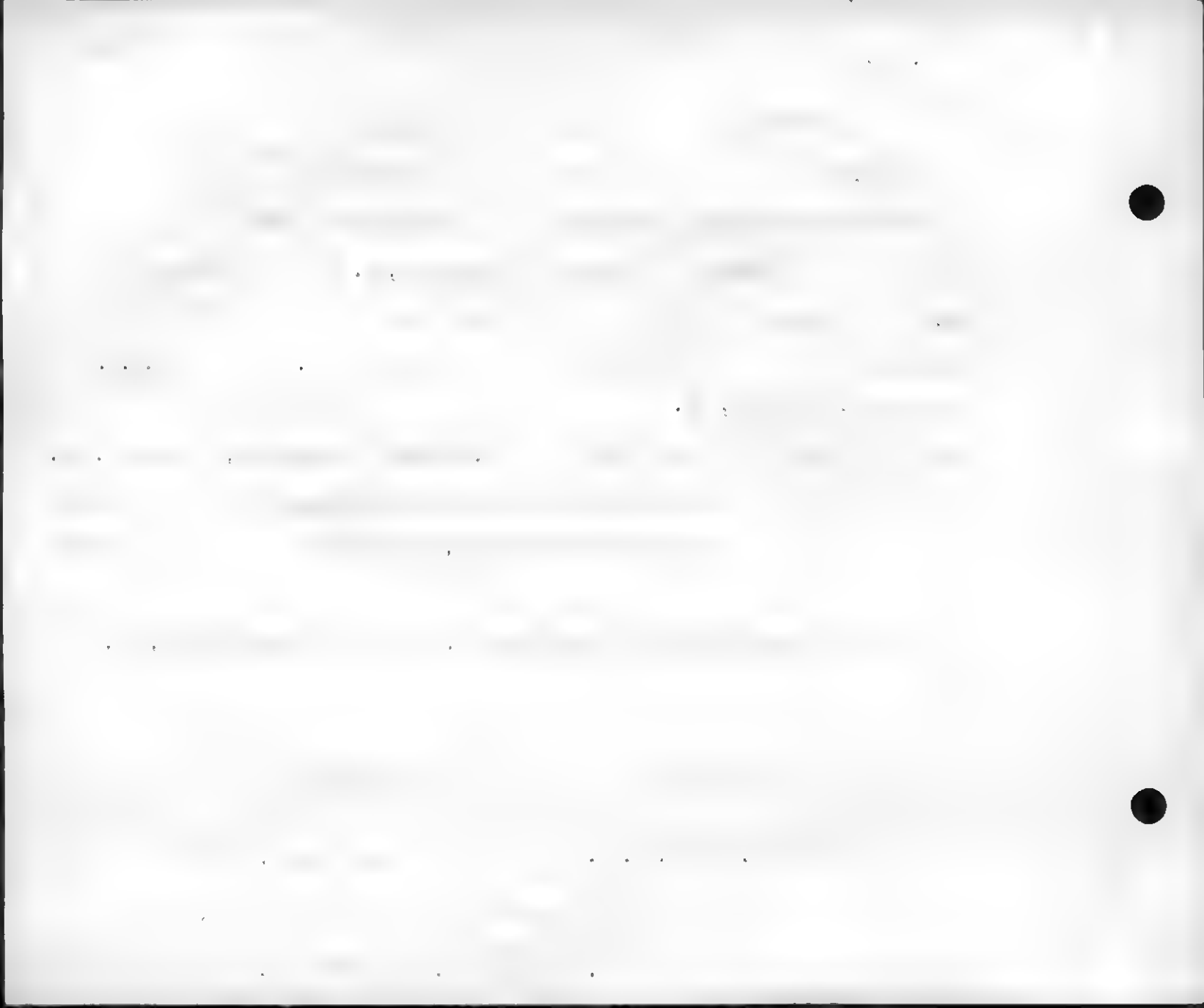
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13600

13594

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 230 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 312 ALBEMARLE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle JEROME Last ROCHFORD, JR.		4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67					
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 26, 1917	9. AGE (In years lost birthday) 50 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIP FITTER		10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT J. ROCHFORD, SR.				14. MOTHER'S MAIDEN NAME ADELAIDE SELLA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 215 05 18 17		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA WITH PULMONARY ABSCESSSES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA, RIGHT LUNG DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE. ARTERIOSCLEROSIS, MARKED, GEN.						9. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 3/2/67 , 19 to 10/18/67 , 19, that (if) (we) lost saw the deceased alive on 10/18/67 , 19, and that death occurred on 10:55 PM from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/20/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/23/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. REC'D BY REGISTRAR OCT 24 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
25c. ADDRESS ZANNINO FUNERAL HOME		25d. ADDRESS 257 S. CONKLING ST. BALTIMORE, MD.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13601

1. PLACE OF DEATH a. COUNTY BALTO. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) e. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FULLERTON				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FULLERTON			
c. LENGTH OF STAY in 1b 10 yrs.				d. STREET ADDRESS 4203 RAAB AVE. BALTO. 21236			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4203 RAAB AVE. BALTO. 21236				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WACLAW J. ROGUSKI				4. DATE OF DEATH OCT. 25 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 5, 1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNACE HELPER		10b. KIND OF BUSINESS OR INDUSTRY COPPER WORKS		11. BIRTHPLACE (Country & State, or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ROGUSKI				14. MOTHER'S MAIDEN NAME BERTHA GIZENSKA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 312-10-1016			
17. US ORIGIN JOSEPHINE ROGUSKI				18. ADDRESS 4203 RAAB AVE BALTO. MD. 21236			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral ischemia, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Terminal pneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-27-64 19... to 10-25-67 19..., that (I) (we) last saw the deceased alive on 10-23-67 19..., and that death occurred 5:15 p.m. on the causes and on the date stated above.							
22a. SIGNATURE <i>Theodore E. Evans</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-25-67	
22c. PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D.				22d. ADDRESS 9660 Belair Road 21236			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.		23d. LOCATION (City, town or county) (State) BALTO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE WM. FIALKOWSKI				25a. REC'D BY REGISTRAR OCT 27 1967			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				25c. ADDRESS 2007 EASTERN AVE BALTO. MD. 21231			

100-100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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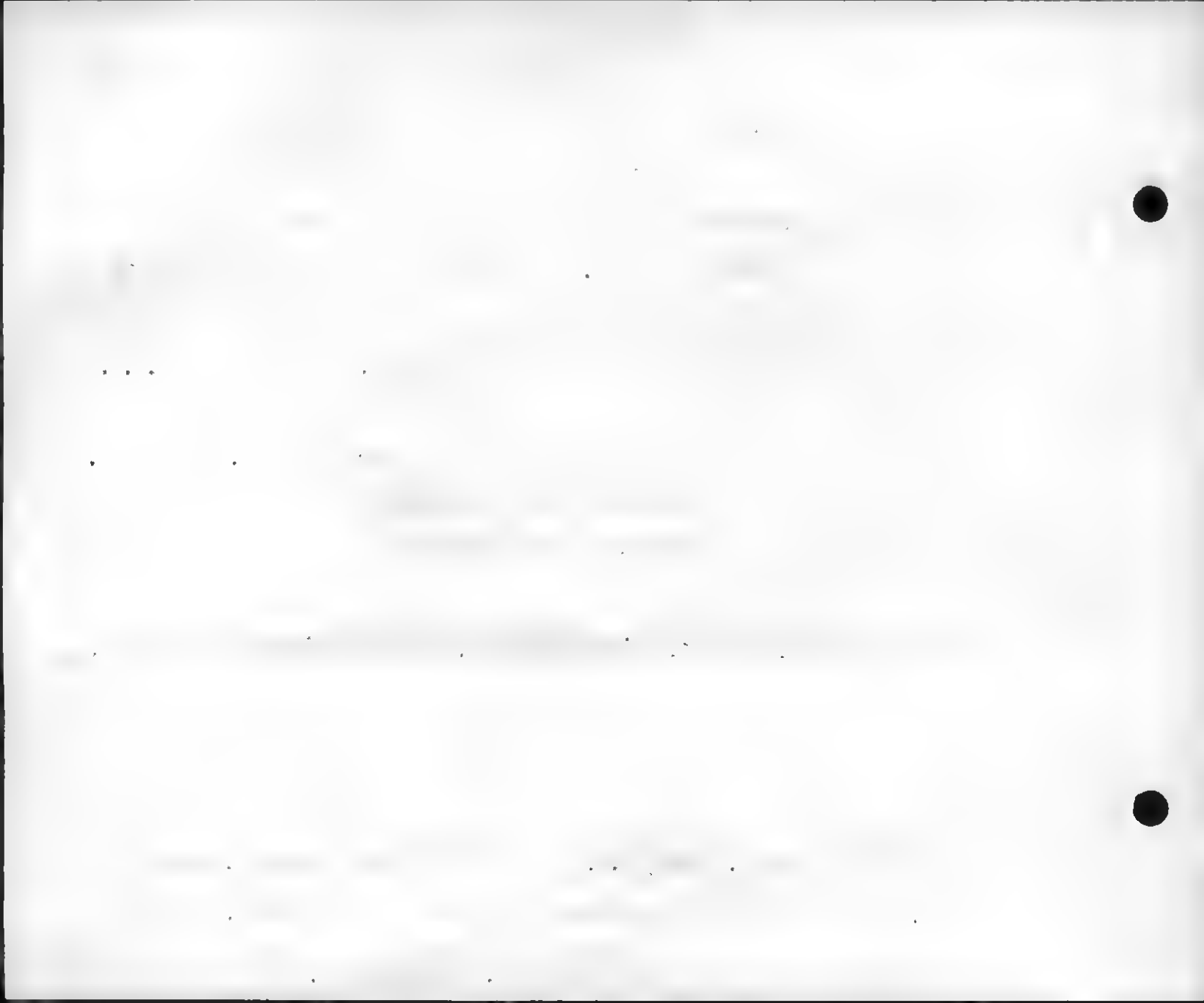
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13596

CERTIFICATE OF DEATH

13602

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1615 PARK AVENUE		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle E. Last ROSEN BROCK				4. DATE OF DEATH Month OCTOBER Day 15 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/90		9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARKING LOT ATTENDANT			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHRISTIAN ROSEN BROCK				14. MOTHER'S MAIDEN NAME MARGARET MILLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI			16. SOCIAL SECURITY NO 219 28 25 87		17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY THROMBOSIS DUE TO (c)							INTERVAL BETWEEN DEATH AND REPORT RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY HEART DISEASE, OLD. PULMONARY EMPHYSEMA, OLD. ARTERIOSCLEROSIS MARKED, GENERALIZED, OLD. BENIGN PROSTATIC HYPERTROPHY, OLD							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 9/29/67 , 19 to 10/15/67 , 19, that (we) last saw the deceased alive on 10/15/67 , 19, and that death occurred at 8:45 AM from causes and on the date stated above							
22a. SIGNATURE <i>Peter V. Juvan</i>				22b. DATE SIGNED 10/16/67		22c. PHYSICIAN'S NAME (Type) PETER V. JUWAN, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10/18/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
24. FUNERAL DIRECTOR				23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		25a. REC'D BY REG. STRAR WITZKE FUNERAL HOME	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				25c. DATE OCT 17 1967			
25d. ADDRESS EDMONDSON AVE. BALTIMORE, MD.							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

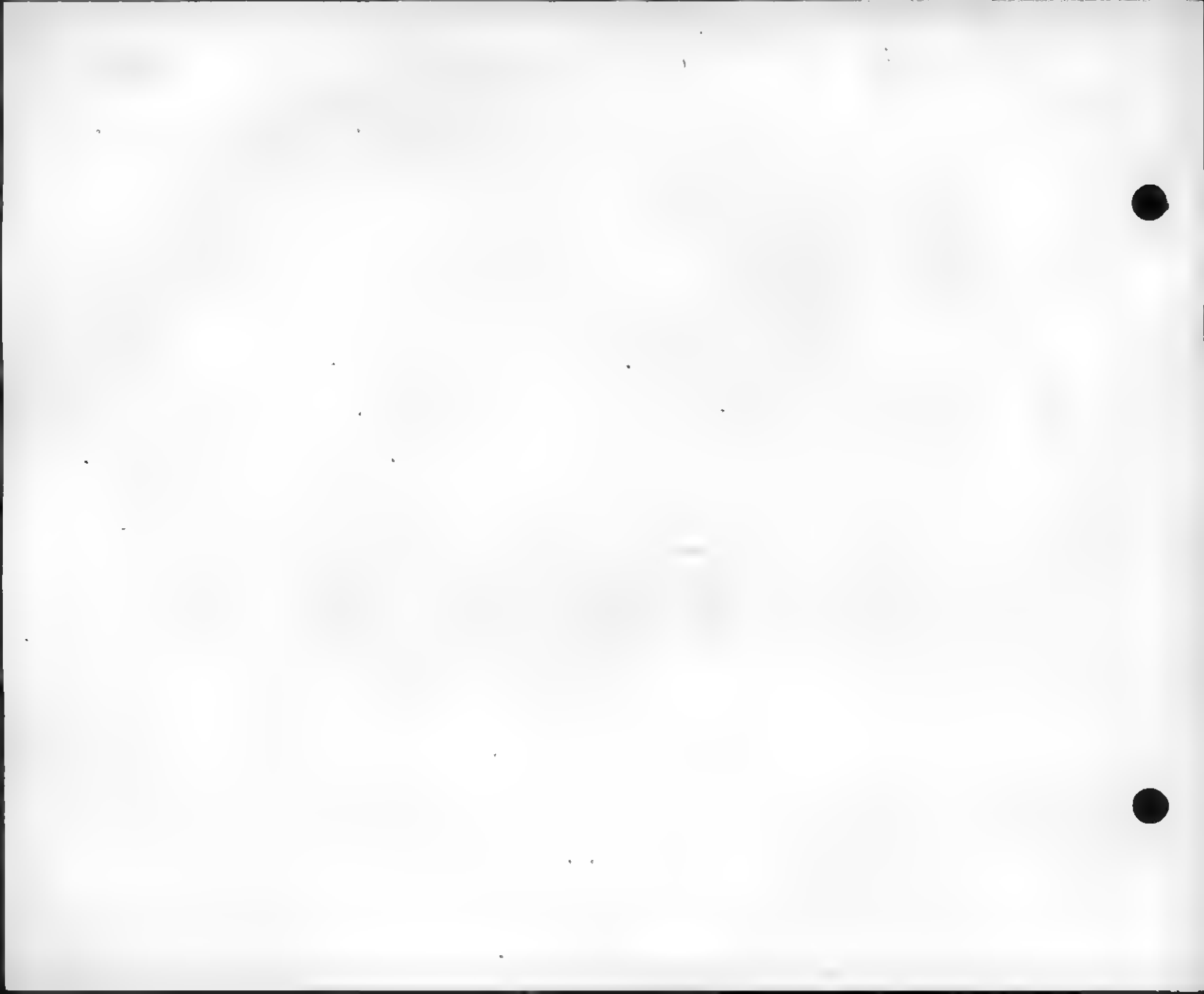
CERTIFICATE OF DEATH

13603

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>309 Church Lane</u>		d. STREET ADDRESS <u>309 Church Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Reginald</u> First Middle Last		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1904</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. BIRTHPLACE (County & State, or foreign country) <u>Chicago Ill.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman for Westinghouse Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Reginald Rosevear Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Jane E. Ireland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>160-03-5195</u>	
17. INFORMANT <u>Mrs. Anne M. Rosevear</u>		Address <u>Pikesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis Coronary Arteriosclerosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 1, 1967</u> to <u>October 4, 1967</u> , that (I) <u>last</u> saw the deceased alive on <u>Sept. 28</u> 1967, and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin Berdann</u>		22b. DATE SIGNED <u>10-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Benjamin Berdann, M.D.</u>		22d. ADDRESS <u>615 Hammonds Lane, Baltimore, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 7, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Philadelphia, Penna.</u>
24. FUNERAL DIRECTOR <u>Tipton-Elme Funeral Home</u>		25a. RECEIVED BY REGISTRAR <u>OCT 6 1967</u>	
ADDRESS <u>Hampstead, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Inge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

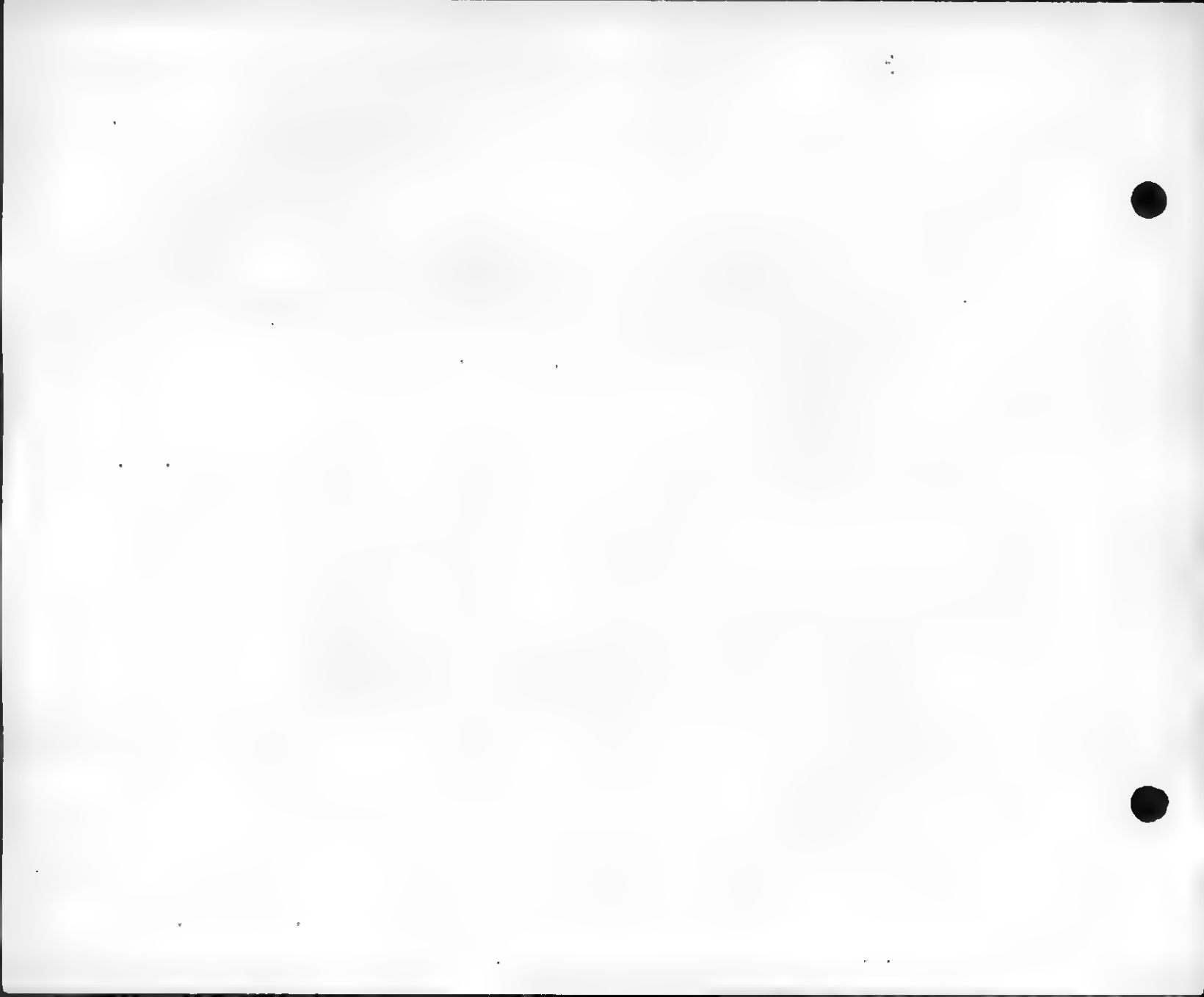
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13601

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8687 Oak Rd 21234		d. STREET ADDRESS 8687 Oak Rd 21234	
3. NAME OF DECEASED (Type or print) First Archie Middle Rosier Last Rosier		4. DATE OF DEATH Month 10 Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 28 Nov 23
9. AGE (In years last birthday) 44 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Bolt Mfgs.	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Rosier		14. MOTHER'S MAIDEN NAME Ida Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 234 30 1341	
17. INFORMANT Harry Rosier		Address Elkins, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4.201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Probable fatal mechanical Coronary Occlusion) DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH undet	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN C. HYLE		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 2577 Belair Rd	
22. DATE SIGNED 10-6-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-9-67	23c. NAME OF CEMETERY OR CREMATORY Mouse Cemetery, Elkins, W. Virginia.	23d. LOCATION (City or town) (County) (State) W. Virginia.
24. FUNERAL DIRECTOR Wm.E. Johnson, 8521 Loch Raven Blvd. 21204		25a. REC'D BY REGISTRAR OCT 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #2394 10/30/67 pm
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13599

13605

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY in lb 4 1/2 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8729 Satyr Hill Road				d. STREET ADDRESS 8729 Satyr Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle JAMES Last ROZNOWSKI				4 DATE OF DEATH Month October Day 23 Year 19 67			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH OCT 7 - 1936	
9 AGE (in years last birthday) 31 yrs		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11 BIRTHPLACE (State or foreign country) Penn		12 CITIZEN OF WHAT COUNTRY USA	
13 FATHER'S NAME John Roznowski				14. MOTHER'S MAIDEN NAME Olga Nightingale			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 211-28-5331		17 INFORMANT Sadie Roznowski		Address Same	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Motor running in closed car					
20c. TIME OF INJURY Month, Day, Year UNK Hour 10/23 am 19 67 p.m.		20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not where <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Garage		20f. (City or town) (County) (State) Baltimore, MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 10/24/67		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-67		23c. NAME OF CEMETERY OR CREMATORY Parkmoor		23d. LOCATION (City or town) (County) (State) Baltimore MD	
24 FUNERAL DIRECTOR Chas F Evans & Son				25a. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13606

13600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 of 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN b. 29½ yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS 919 Homestead Street			
3. NAME OF DECEASED (Type or print) First Eugene Middle Francis Last RUETER				4. DATE OF DEATH Month 10 Day 10 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-29	9. AGE (In years last birthday) 38 yrs	IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent	
10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md. 9		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Bernard Rueter				14. MOTHER'S MAIDEN NAME Marie Anthony			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Chronic Glomerular Nephritis DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 6 yrs. terminal	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(c))						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from 12/29 , 19 37 , to 10/10 , 1967, that (1) we last saw the deceased alive on 10/10 , 19 67 , and that death occurred at 5:50 p.m. from causes and on the date stated above.							
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 11 Oct 67		22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/1967		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Eugenia K. Seitz Seitz Funeral Home				25a. DATE OCT 13 1967		25b. REGISTRAR'S SIGNATURE Judge	

الحمد لله الذي جعل
العلم نوراً يضيء
القلوب ويهدي
السلوك

بسم الله الرحمن الرحيم
الحمد لله الذي جعل

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

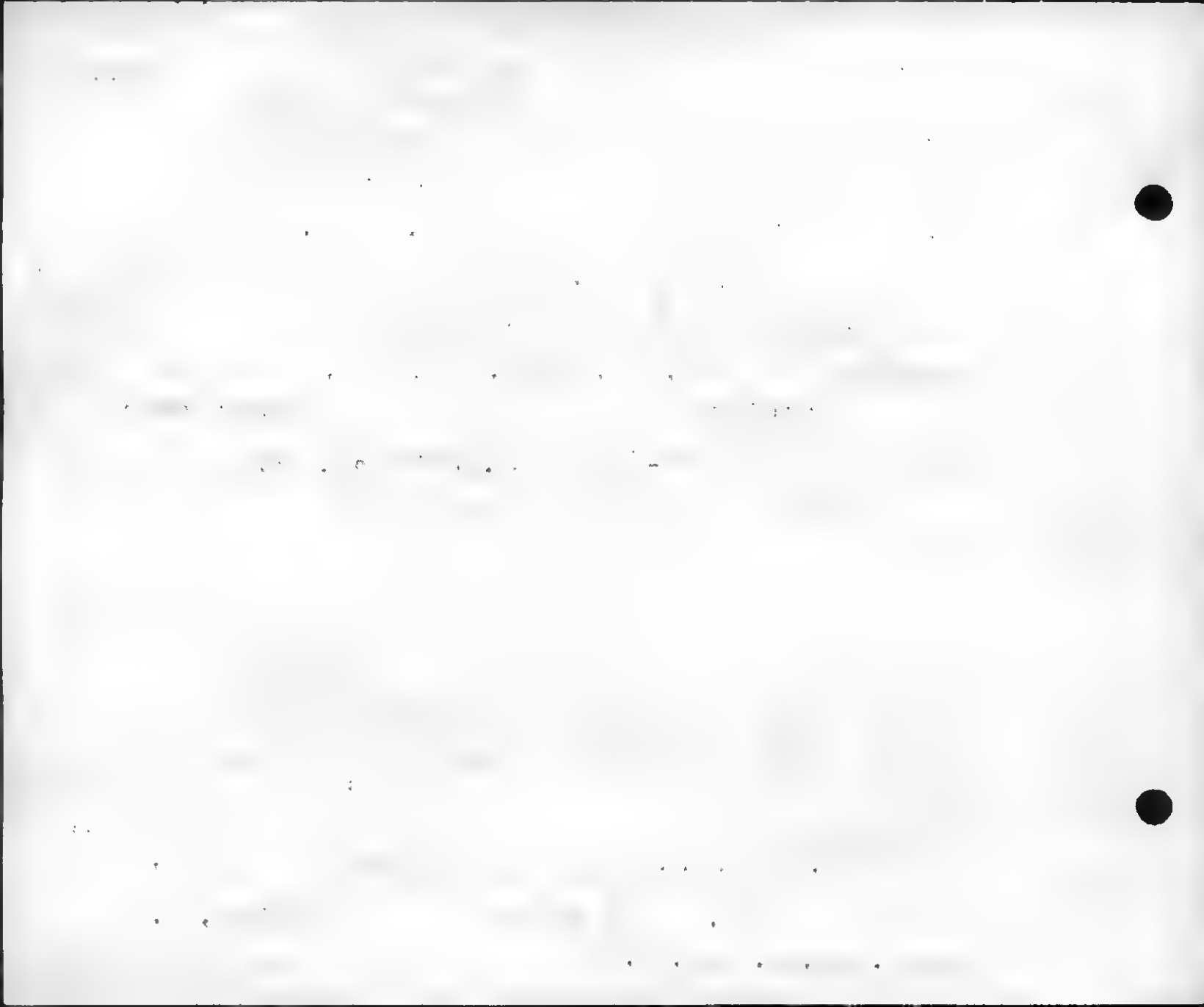
CERTIFICATE OF DEATH

12601

13607

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				e. STREET ADDRESS 341 S. Drew St. #21224			
3. NAME OF DECEASED (Type or print) First Middle Last Harry J. SCANDORA				4. DATE OF DEATH Month Day Year October 3 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1918		9. AGE (n years last b rthday) 49 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Galvanizer			11b. KIND OF BUSINESS OR INDUSTRY Gen. Elec. Insulat.		11. BIRTHPLACE (County & State or foreign country) New York City, New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Santo Vasta				14. MOTHER'S MAIDEN NAME Angelina Scandora			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W 2			16. SOCIAL SECURITY NO 218-03-9687		17. INFORMANT Mrs. Antoinette R. Scandora		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO RESPIRATORY COLLAPSE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METABOLIC DISTURBANCE DUE TO (c) CARCINOMA OF THE LUNG AND LIVER						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 12, 1967 , to October 3, 1967 , that (I) (we) last saw the deceased alive on October 3, 1967 , and that death occurred at 3:00AM from causes and on the date stated above.							
22a. SIGNATURE B. Olives					22b. DATE SIGNED October 3, 1967		22c. PHYSICIAN'S NAME (Type) B. Olives, M.D.
22d. ADDRESS 7620 York Road Towson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/67.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE OCT 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and return event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

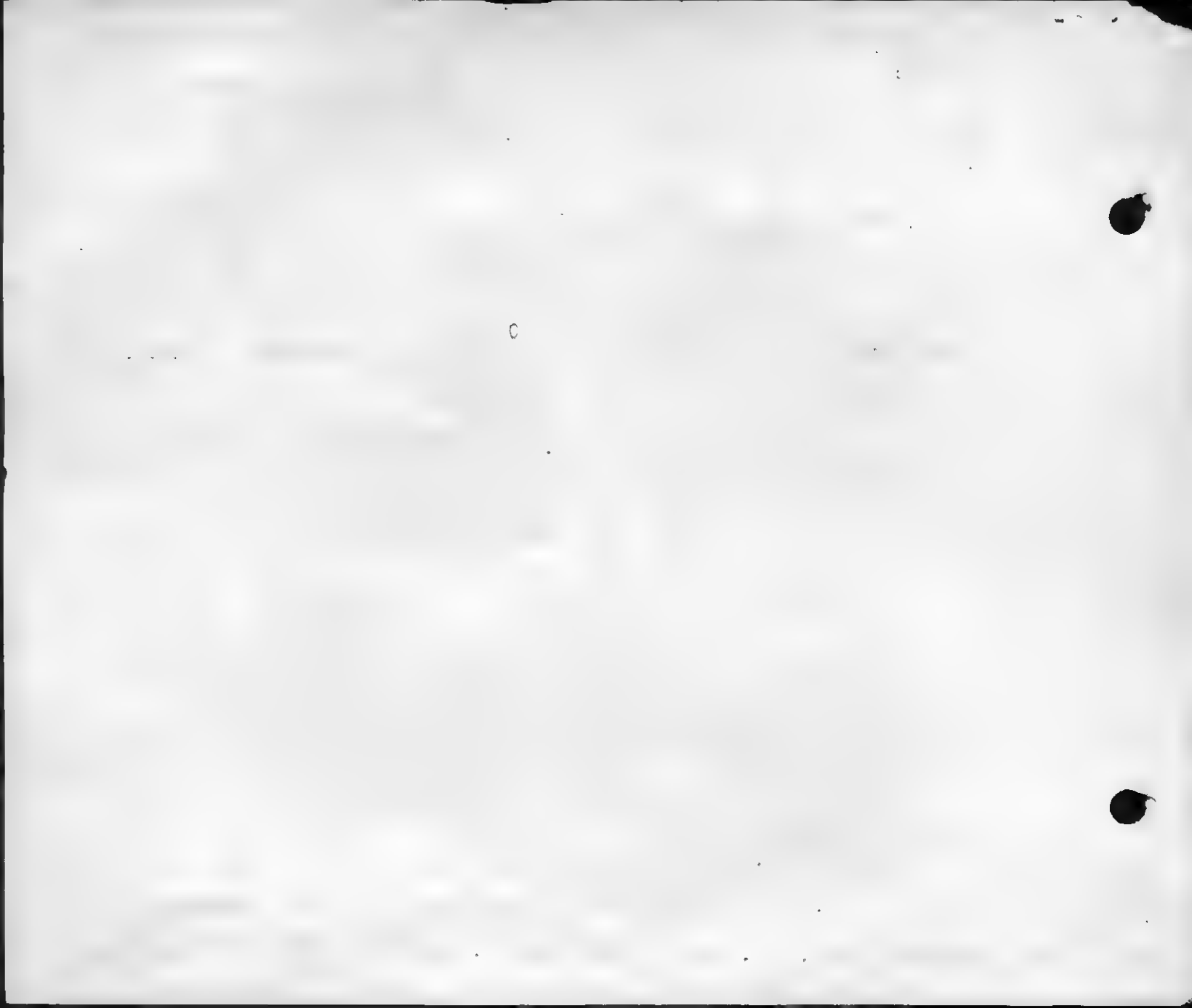
CERTIFICATE OF DEATH

13602

13608

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b <u>Baltimore</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3233 Greenmeade Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First Middle Last <u>SCHAEFFER</u>		4. DATE OF DEATH <u>OCT. 6 1967</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (in years last birthday) <u>77</u> Months Days Hours Min.
13. FATHER'S NAME <u>MEYER COHEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MR. ALBERT SCHAEFFER, 3107 BETLOU JAMES PL. #7</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) DUE TO (c) <u>Acute Heart Failure</u> <u>Acute Myocardial Infarction</u> <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>6 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> to <u>10-6</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> - <u>1967</u> , and that death occurred at <u>10-6</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba</u> M.D.		22b. DATE SIGNED <u>10-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MADAMBA</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-8-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KNESSETH ISRAEL KOLK WOLYN</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

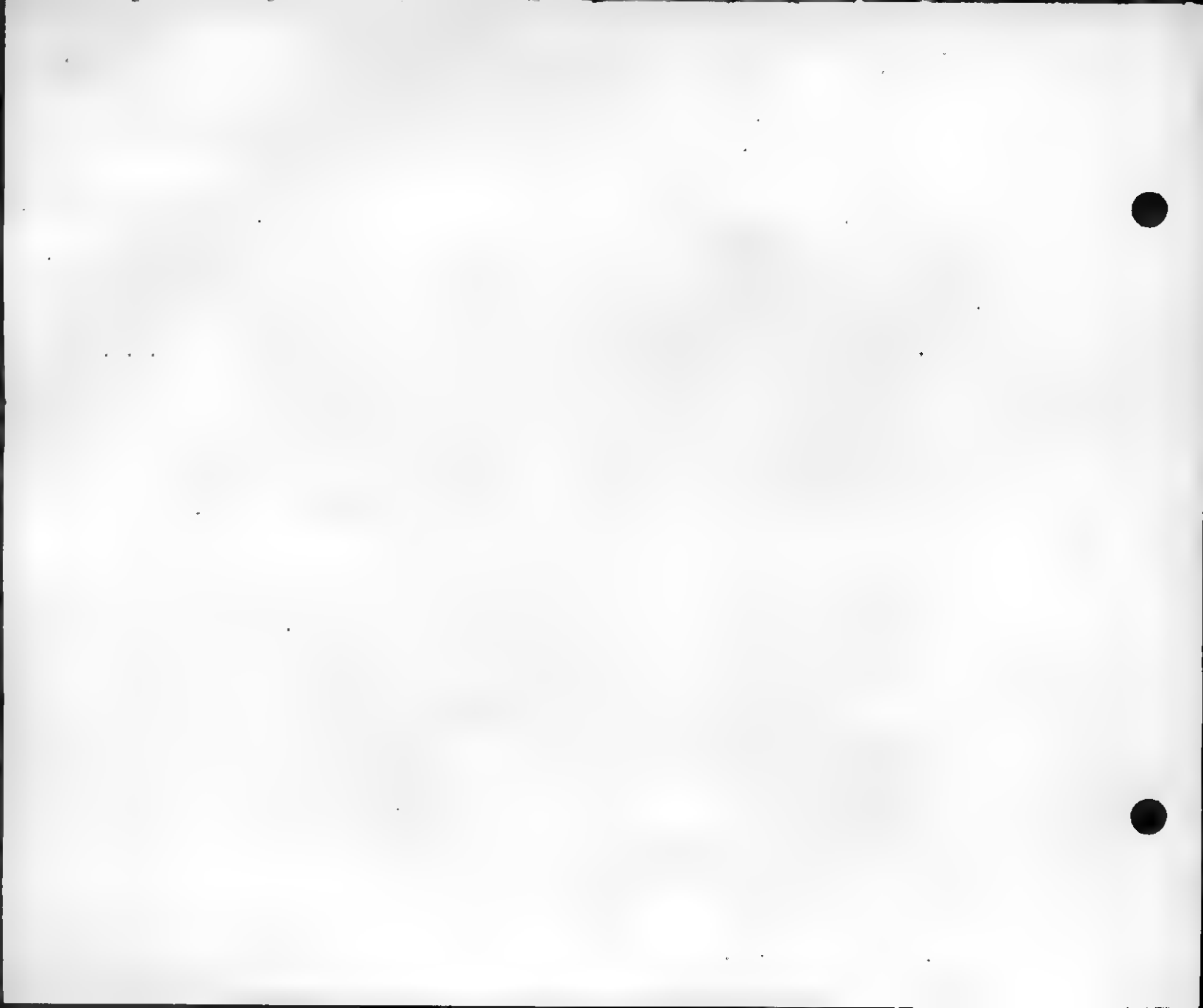


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
<div style="display: flex; justify-content: space-between;"> 13603 Items #2c & d Film 10/20/67 ph 13609 </div>											
1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">Baltimore County</div>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <div style="text-align: center;">Maryland</div> b. COUNTY <div style="text-align: center;">Baltimore</div>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">MARYLAND</div>						c. LENGTH OF STAY IN 1b <div style="text-align: center;">Baltimore 21205</div>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center;">Armcast Nursing Home</div>						d. STREET ADDRESS 1157 Fraley Way <div style="text-align: center;">812 Regester Ave.</div>					
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">Lydia</div>						4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> First <div style="text-align: center;">Lydia</div> </div> <div> Middle <div style="text-align: center;">Schmidt</div> </div> <div> Last <div style="text-align: center;">Schmidt</div> </div> </div>					
5. SEX <div style="text-align: center;">Female</div>		6. COLOR OR RACE <div style="text-align: center;">Cauc.</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center;">7/5/98</div>		9. AGE (In years last birthday) <div style="text-align: center;">69 yrs.</div>		IF UNDER 1 YEAR IF UNDER 24 HRS. <div style="display: flex; justify-content: space-between;"> <div> Months <div style="text-align: center;">30.4</div> </div> <div> Days <div style="text-align: center;">19</div> </div> <div> Hours <div style="text-align: center;">67</div> </div> </div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Retired Nurse</div>						10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">New Kensington, Pa.</div>					
11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">U.S.A.</div>						12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>					
13. FATHER'S NAME <div style="text-align: center;">August Bartsch</div>						14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Elizabdtth Holwartz</div>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center;">No</div>						16. SOCIAL SECURITY NO. <div style="text-align: center;">219-30-7417</div>		17. INFORMANT <div style="text-align: center;">Simon Schonfield 1101 Tower building</div>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, metastatic advanced, on the left endometrium</i> <div style="margin-top: 10px;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) </div> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;"> INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center;">8 yrs</div> </div> </div>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="text-align: center;">Hypertensive Cardio Vascular Disease</div>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <div style="display: flex; justify-content: space-between;"> <div>Hour a.m. p.m.</div> <div>19</div> </div>		20d. INJURY OCCURRED <div style="display: flex; justify-content: space-between;"> <div>While at work <input type="checkbox"/></div> <div>Not While at work <input type="checkbox"/></div> </div>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 3-21-1962, to 10-17-1962, that (I) (we) last saw the deceased alive on 10-17-1962, and that death occurred at 2:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <div style="text-align: center;">Juri Hirano</div>						22b. DATE SIGNED <div style="text-align: center;">10-18-67</div>					
22c. PHYSICIAN'S NAME (Type) JURI HIRANO						22d. ADDRESS 5802 Frankford ave 13. St. more, Md 21206					
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		23b. DATE THEREOF <div style="text-align: center;">10/20/67</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Oak Lawn Cemetery</div>		23d. LOCATION (City, town or county) (State) <div style="text-align: center;">Baltimore, Maryland</div>					
24. FUNERAL DIRECTOR <div style="text-align: center;">Wm. Cook-Brooks Inc. Baltimore, Md. 21202</div>						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <div style="display: flex; justify-content: space-between;"> <div> DATE OCT 23 1967 </div> <div> <i>Charles Judge</i> </div> </div>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

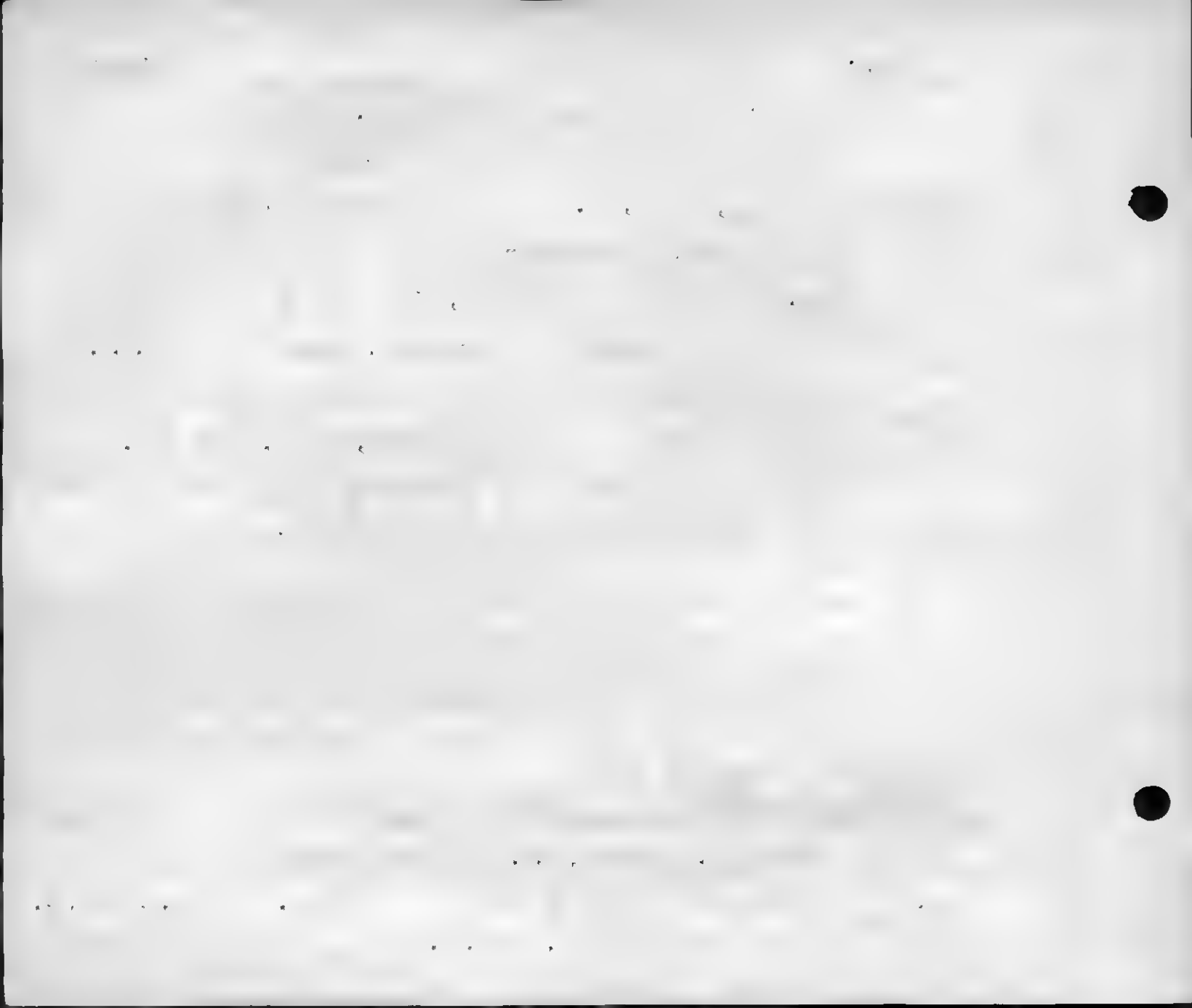
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13804

13610

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY /			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1001 West Joppa Road, Towson, Md.				d. STREET ADDRESS 1001 West Joppa Road			
3. NAME OF DECEASED (Type or print) Sister Mary Augustine Schneider				4. DATE OF DEATH OCT. 9 1967			
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1879	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 9 Days 9		IF UNDER 24 HRS. Hours 19 Min. 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun				10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (County & State, or foreign country) Heuchelheim, Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry Schneider			
14. MOTHER'S MAIDEN NAME Catherine Kroeck				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Convent Records, 1001 W. Joppa Road.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/17 19 57 to 10/9 19 67 , that (I) (we) last saw the deceased alive on 10/9 19 67 , and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Charles F. O'Donnell, M.D.				22b. DATE SIGNED 10/11/67			
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.				22d. ADDRESS 7501 York Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/1967		23c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		23d. LOCATION (City, town or county) (State) 1001 W. Joppa Rd. Towson, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Gannon				25a. REC'D BY REGISTRAR OCT 13 1967			
25b. REGISTRAR'S SIGNATURE Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13605

13611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN It Ellicott City d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHADY NOOK NURSING HOME, ROLLING RD.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 24 Tyler Drive e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last SCHNEIDER		4 DATE OF DEATH Month OCT. Day 13, Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Fuller R. Wright		14. MOTHER'S MAIDEN NAME Mary Warfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	17. INFORMANT Address Mrs. Lillian Leidner, 24 Tyler Drive 21043
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial failure - 48 hrs. DUE TO (b) Generalized intrauterine carcinoma DUE TO (c) origin undetermined.			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis C.V. disease.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 1967, to Oct. 13 , 1967, that (I) (we) last saw the deceased alive on Oct. 12 , 1967, and that death occurred at 7:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE D. C. MacLaughlin		22b. DATE SIGNED 10/13/67	22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin
22d. ADDRESS Shady Nook Nursing Home, Catons. Md.		22e. REC'D BY REGISTRAR DATE OCT 16 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/16/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25b. REGISTRAR'S SIGNATURE Charles Jones	



7 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13606

CERTIFICATE OF DEATH

13612

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>307 E. Pennsylvania Ave</u>		d. STREET ADDRESS <u>307 E. Pennsylvania Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G.</u> Last <u>Schorr Sr.</u>		4. DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 13, 19 25</u>
9. AGE (in years last birthday) <u>42</u> yrs		10. F UNDER 1 YEAR Months Days 11. F UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grounds keeper retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>unknown dead</u>		14. MOTHER'S MAIDEN NAME <u>unknown dec'd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO <u>212-32-2876</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>56</u> , to <u>10/13</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>10/12</u> , 19 <u>67</u> and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.		22b. DATE SIGNED <u>10/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		22d. ADDRESS <u>7501 York Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Morland Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Parkville Md.</u>
24. FUNERAL DIRECTOR <u>John Evans Sons</u>		25a. REC'D BY REGISTRAR <u>Towson, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 19 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

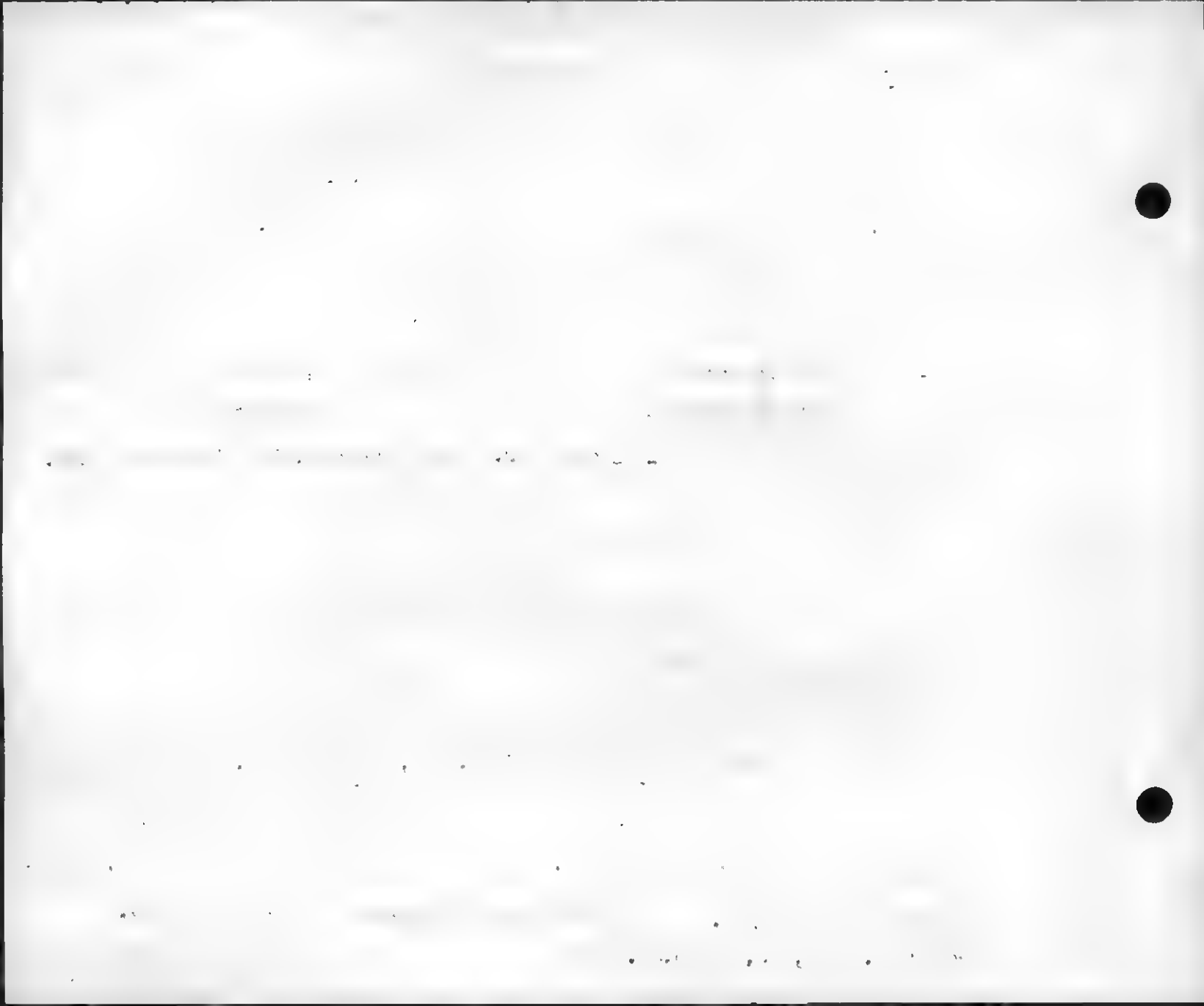
CERTIFICATE OF DEATH

12807

13613

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21214</u> d. STREET ADDRESS <u>2720 Northern Pkwy.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Schurman</u>				4. DATE OF DEATH Month Day Year <u>October 12 1967</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 24, 1887</u>		9. AGE (In years last birthday) yrs <u>80</u>		10. IF UNDER 1 YEAR Months Days Hours M.n. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Tool & Die Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Adolph Schurman</u>				14. MOTHER'S MAIDEN NAME <u>Marie Monberger</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>216-10-0229</u>		17. INFORMANT Address <u>Mr. Harold Schurman, 6149 Chinquapin Pkwy.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary embolisms</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 		20f. (City or town) (County) (State) 			
21. I certify that (A) (this hospital) attended the deceased from <u>Sept. 3rd, 1967</u> , to <u>Oct. 12th 1967</u> , that (A) (we) last saw the deceased alive on <u>October 12 1967</u> , and that death occurred at <u>3:25 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Lawrence F. Misanik, M.D.</u> M.D.								22b. DATE SIGNED <u>10-12-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lawrence F. Misanik, M.D.</u>								22d. ADDRESS <u>7620 York Rd. Towson, Md. 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/14/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>						25a. REC'D BY REGISTRAR DATE <u>Oct 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove earlier pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13614

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2902 Dunleer Road		d. STREET ADDRESS 2902 Dunleer Road e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) SARAH SHEPHERD SCHWING First Middle Last		4 DATE OF DEATH October 2, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 25, 1916
9 AGE (In years last birthday) 51 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob E. Shepherd	
14. MOTHER'S MAIDEN NAME Sallie Moore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) NO (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Address Dr. Harold E. Schwing 2902 Dunleer Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive C.V. Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 yrs		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 2, 1967 to Oct 2, 1967 that (I) (we) last saw the deceased alive on Oct 2, 1967 and that death occurred at 6:59 A.M. from causes and on the date stated above.			
22a. SIGNATURE M.B. Davis		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) M.B. Davis, M.D.		22d. ADDRESS 6800 Mornington Road	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d LOCATION (City or Town) (County) (State) Colgate, Md.
24 FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR DATE OCT 5 1967	25b REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

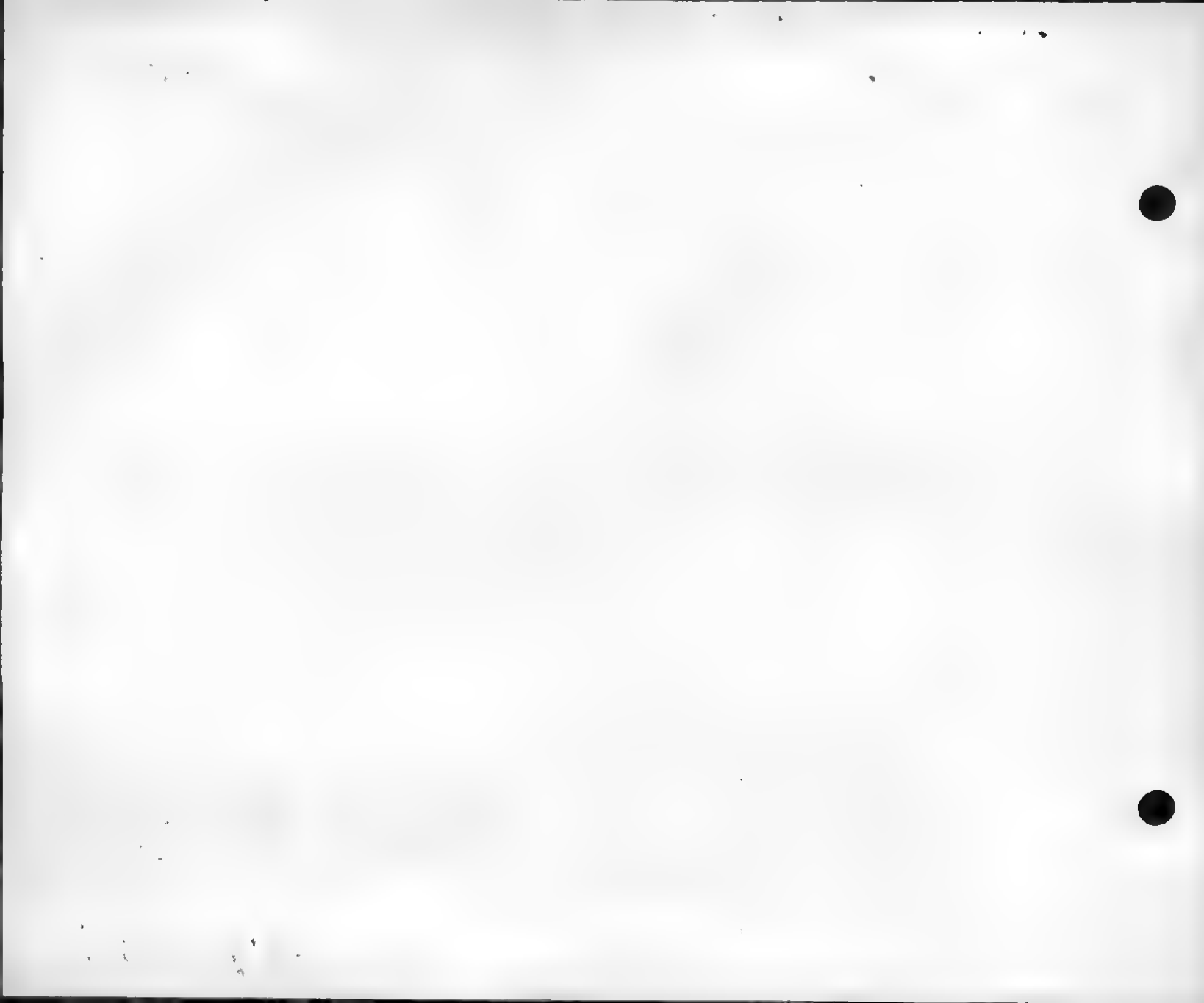
CERTIFICATE OF DEATH

13615

10008

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>			c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>				d. STREET ADDRESS <u>510 W. Shopley Rd., Littleton</u>		e. IS RES. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eldridge E. Sears</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>7/24/85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>work</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>work</u>		16. SOCIAL SECURITY NO. <u>705-08-1096</u>		17. INFORMANT <u>Hosp Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>30 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u>							19. WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> , 19 <u>67</u> , to <u>10/15</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>10/15</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. E. Zink</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. Zink</u>				22d. ADDRESS <u>414 W. Lane, Ellicott City, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>13 Oct. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Galesville, AA Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>Oct 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13610

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>201 Goodwood Road</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs 25 min</u>		d. STREET ADDRESS <u>201 Goodwood Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>San Clark Sener</u>		4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/1924</u>
9. AGE (In years, last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Stanford Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John A. Ten Eyke</u>		14. MOTHER'S MAIDEN NAME <u>Partridge, Florence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>049-165317</u>	
17. INFORMANT <u>Patients Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Symptomatic Carcinomatosis in both lungs</u> DUE TO (c) <u>Secondary to Rt. breast C.A.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6 P.M. 10-2</u> , 19 <u>67</u> , to <u>9:25 10-3-1967</u> , that (I) (we) last saw the deceased alive on <u>9-24 10-2</u> , 19 <u>67</u> , and that death occurred at <u>9:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rahim Bassir</u>		22b. DATE SIGNED <u>10-2-67 9:30</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rahim Bassir</u>		22d. ADDRESS <u>GBMC, Towson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>10-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd., Balto</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

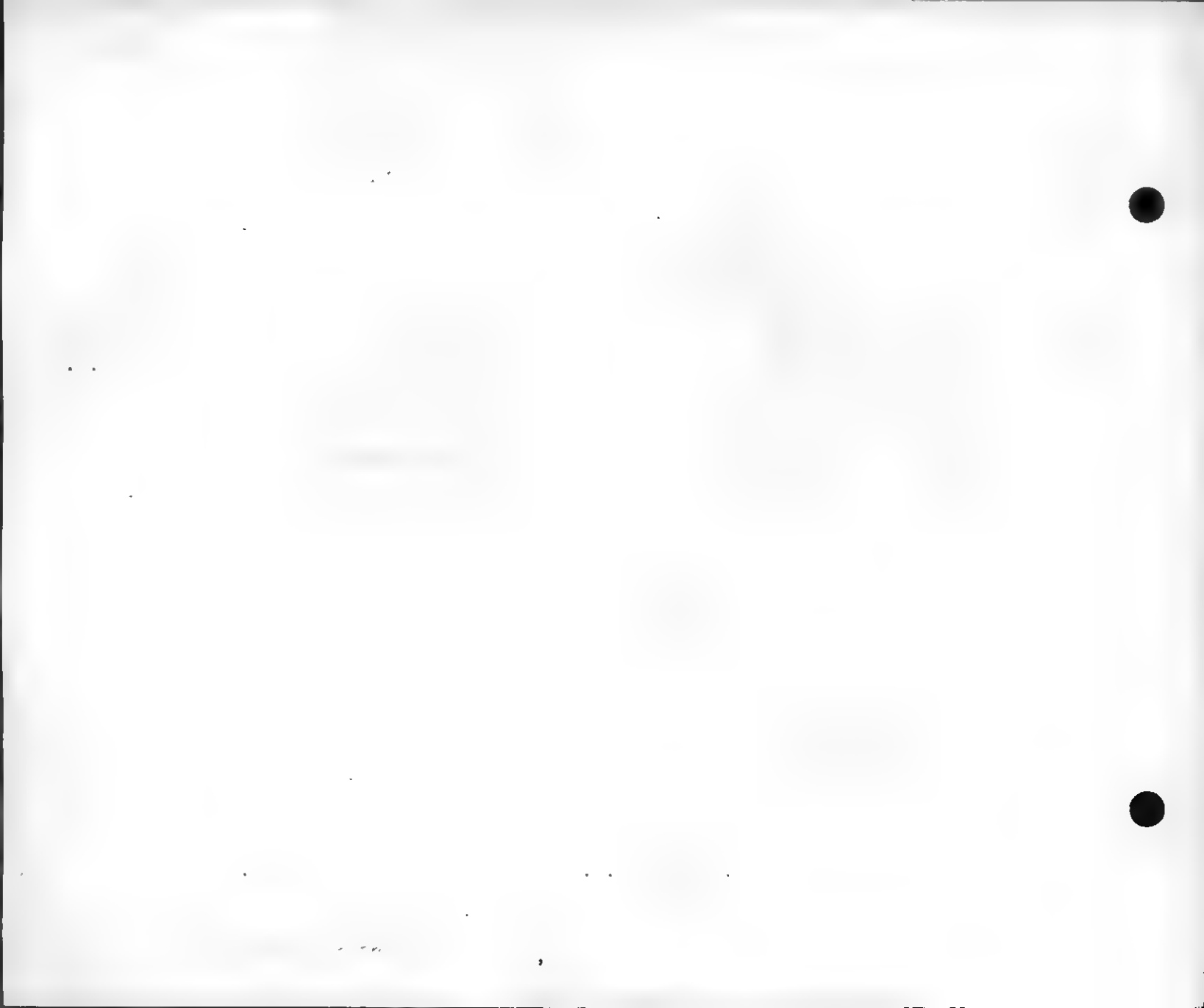
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13617

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN b 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 29 Patuxent Mobile Estates	
3. NAME OF DECEASED (Type or print) First Sandra Middle Jean Last SHAW		4. DATE OF DEATH Month 10 Day 16 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-66
9. AGE (In years lost birthday) 1 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Ann Arbor, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Harold Shaw		14. MOTHER'S MAIDEN NAME Carol Jean Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute passive Congestive Pulmonary DUE TO terminal (b) Cerebral insufficiency DUE TO 1 year (c) Noncommunicating Hydrocephalus 17 months		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10/3 , 19 67 , to 10/16 , 19 67 that (2) (we) last saw the deceased alive on 10/16 , 19 67 , and that death occurred at 7:45am , from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 10-16-67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22d. ADDRESS Rosewood State Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/67	
23c. NAME OF CEMETERY OR CREMATORY Glen Eden Lutheran		23d. LOCATION (City or town) (County) (State) Wayne Co. Michigan	
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.		25a. REC'D BY REGISTRAR Oct 18 1967	
25b. REGISTRAR'S SIGNATURE William S. Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 21222	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital		d. STREET ADDRESS 222 S. Wilson St. R.I.	
3. NAME OF DECEASED (Type or print) First Walter Middle Brock Last SHAW, Sr.		4. DATE OF DEATH Month October Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-94
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR RAIL ROAD		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	
11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-6496	
17. INFORMANT Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car Automobile 5711 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Preliminary Impression DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 62 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-18 , 19 67 , to 10-19 , 19 67 , that (I) (we) last saw the deceased alive on 10-19 , 19 67 , and that death occurred at 11 p. M, from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 10-19-67	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D. Supt.		22d. ADDRESS Mt. Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/23/67	23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE	23d. LOCATION (City or Town) (County) (State) DORSEY, Md.
24. FUNERAL DIRECTOR W. Rivin Beachley, Dundalk, Md.		25a. REC'D BY REGISTRAR DATE OCT 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

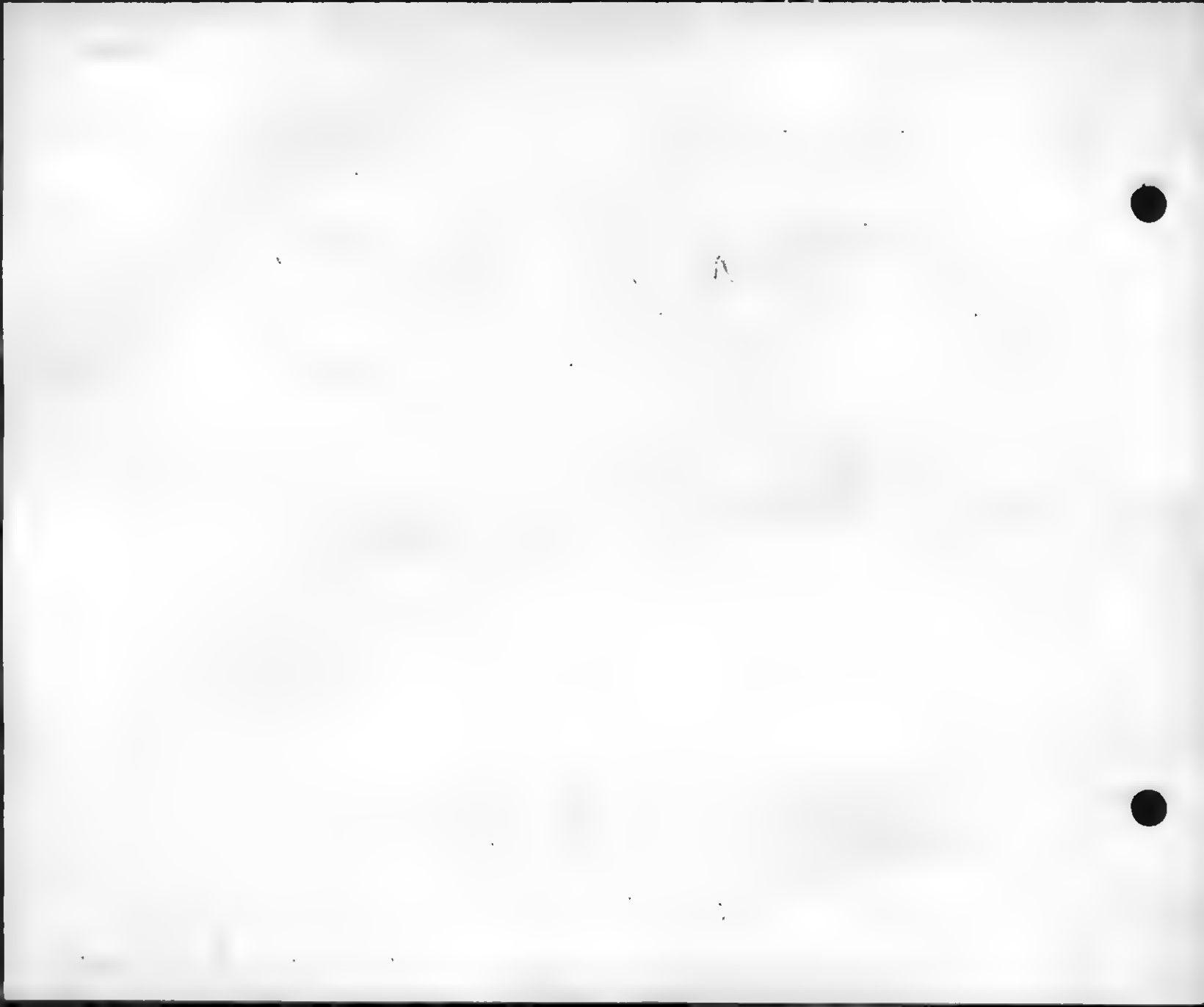
13619

13613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>8 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1300 Poplar Ave.</u>				d. STREET ADDRESS <u>1300 Poplar Ave.</u>			
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Shek</u>				4 DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/10/81</u>	9 AGE (In years last birthday) <u>86</u> yrs	10 UNDER 1 YEAR Months <u> </u> Days <u> </u>	11 UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Kreiner</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-48-4955</u>		17. INFORMANT <u>Dolores Shek 1300 Poplar Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombotic cardiac vascular disease</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>67</u> to <u>Oct 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 9</u> , 19 <u>67</u> , and that death occurred at <u>10</u> M. from causes and on the date stated above.							
22a. SIGNATURE <u>Edgar Williamson</u>				22b. DATE SIGNED <u>10/16/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Edgar Williamson</u>	
22d. ADDRESS <u>5550 Balto. National Pk</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Ambrose Inc 1329 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR <u>DA OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE HEALTH DEPT

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

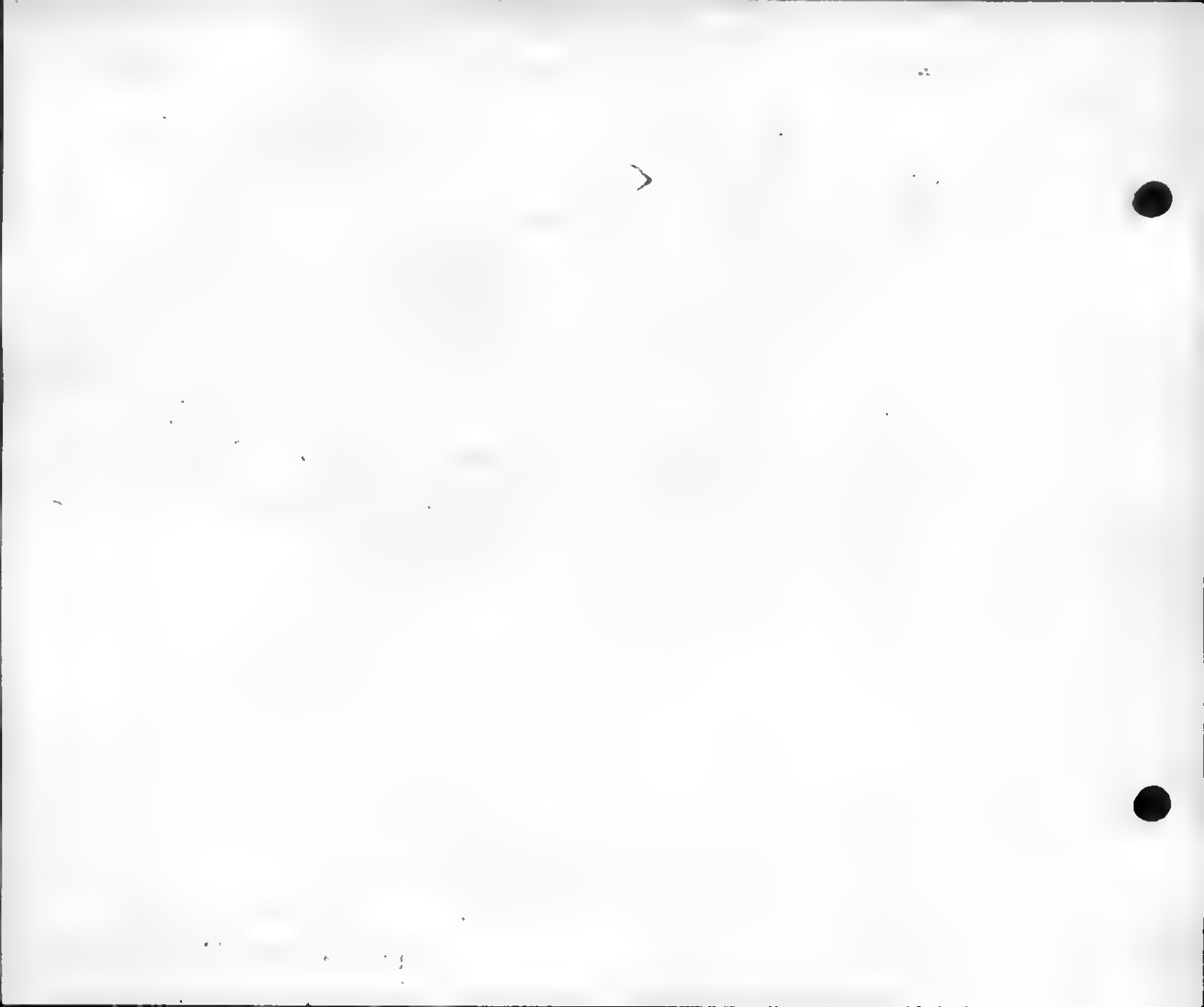
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15614

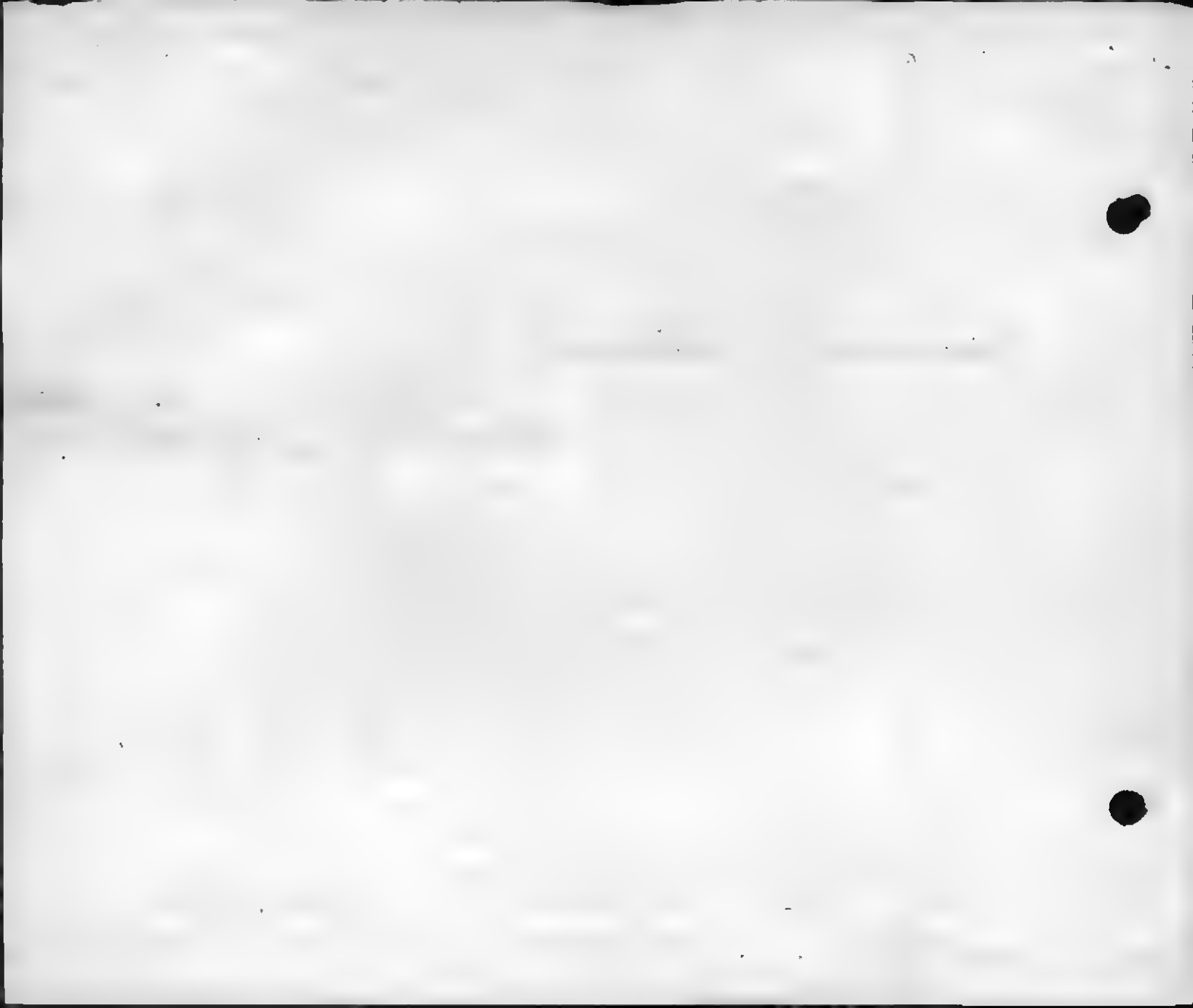
13620

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c LENGTH OF STAY IN 1b <u>Woodstock, Md</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. County General Hospital</u>		d STREET ADDRESS <u>Wrights Mill Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Gilbert K. Shifflett</u>		4 DATE OF DEATH Month <u>10</u> / Day <u>14</u> / Year <u>1967</u>	
5 SEX <u>m</u>	6 CO. OR RACE <u>w</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/30/02</u>
9 AGE (In years last birthday) <u>65</u> yrs		10 UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Cotton Mill</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u> </u>	
13 FATHER'S NAME <u>Silas William Shifflett</u>		14 MOTHER'S MAIDEN NAME <u>Susanna Mobrey</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>216-07-4015</u>	
17 INFORMANT <u>FANNIE SHIFFLETT</u>		Address <u>Wrights Mill Rd Woodstock, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> <u>4241</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>problem</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. N. Frederick md</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. N. Frederick md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>1311 Francis Ave Balto. Md. 21227</u>	
22a BLURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>10-18-67</u>	<u>LAKE VIEW</u>	<u>54 KESVILLE CARROLL and</u>
24 FUNERAL DIRECTOR <u>Shirley R. Slagter</u> <u>Highland - Stark Elm St City</u>	25a REC'D BY REGISTRAR <u>OCT 18 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



13621

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLS TOWN</u> c. LENGTH OF STAY IN TB <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE Co. General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>7902 Dunhill Village Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) First <u>Abraham</u> Middle <u>—</u> Last <u>Shuster</u> 4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1967</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-25-96</u> 9. AGE (In years last birthday) <u>71</u> yrs IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX GROCER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Poland.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sidney Shuster</u> 14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX</u> <u>ETHEL I</u> <u>MRS. MARY SHUSTER</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>W.W.I.</u> 16. SOCIAL SECURITY NO <u>088-16-4219</u> 17. INFORMANT <u>XXXXXXXXXX</u> Address <u>7902 DUNHILL VILLAGE CIRCLE, APT. 104</u> INTERVAL BETWEEN ONSET AND DEATH <u>104</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u> DUE TO (b) <u>Pulmonary Infarct</u> (c) <u>Acute Pulmonary Edema 2° ASCP</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>10-2</u> <u>1967</u> to <u>10-6</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> <u>1967</u> , and that death occurred at <u>5:45 pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Diadema Simon, M.D.</u> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 22d. ADDRESS 22e. ATTENDING PHYS. <input type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SWINICHER WOLINER</u> 23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD</u> 24a. ADDRESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>OCT 11 1967</u> <u>Charles Judge</u>	

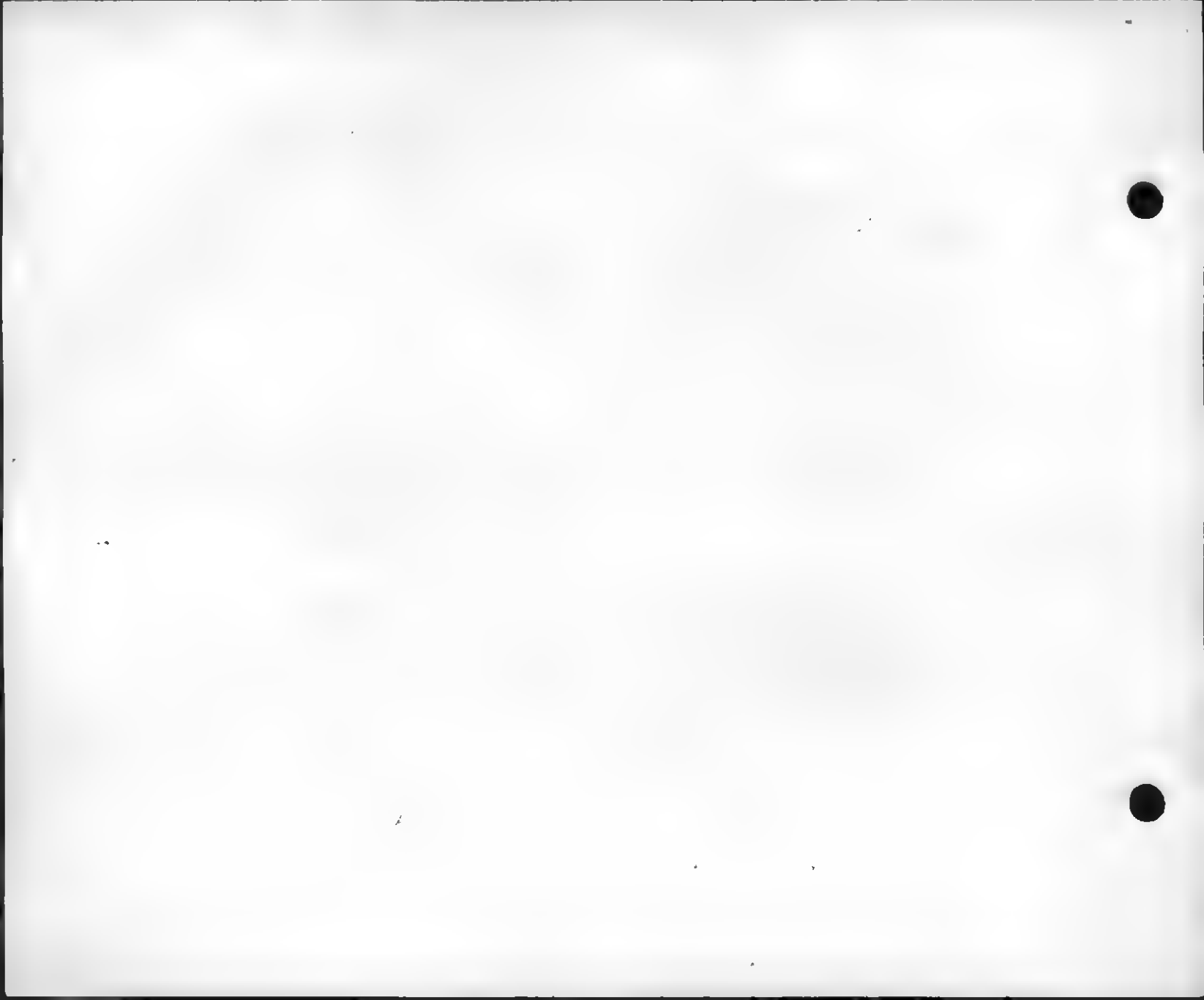


13622

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6009 UPDALE COURT		d. STREET ADDRESS 6009 UPDALE COURT #21207	
3. NAME OF DECEASED (Type or print) First BESSIE Middle SIEGEL Last		4. DATE OF DEATH Month OCTOBER Day 9 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13, 1886
9. AGE (In years last birthday) 81 Yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB FRANK		14. MOTHER'S MAIDEN NAME MARGOLA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MISS ESTHER FRANK SIEGEL, XXXX6009 UPDALE CT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hr 10+ years
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HCVD			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 19 60 , to 9 Oct , 19 67 that (I) (we) last saw the deceased alive on 9 Oct , 19 67 , and that death occurred at 11 A M, from causes and on the date stated above.			
22a. SIGNATURE DR. MARVIN H. DAVIS		22b. DATE SIGNED 10 Oct 1967	
22c. PHYSICIAN'S NAME (Type) DR. MARVIN H. DAVIS		22d. ADDRESS 6512 LIBERTY ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-12-67	23c. NAME OF CEMETERY OR CREMATORY BETH ISRAEL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC., 6010 REISTERSTOWN RD.		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13617

CERTIFICATE OF DEATH

13623

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Lancaster</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pilmerock</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4412 Ridge Ave</u>		d. STREET ADDRESS <u>4412 Ridge Ave</u>	
3. NAME OF DECEASED (Type or print) <u>SUSIE T. SIMMONS</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Whitestone, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Temple Towles</u>		14. MOTHER'S MAIDEN NAME <u>Sidney Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>234-42-1952B</u>	
17. INFORMANT <u>George R. Simmons</u> Address <u>4412 Ridge Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Generalized Metastases see to @</u> DUE TO (c) <u> </u>			19. INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> , 19 <u>67</u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>3:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Manuel Rodriguez</u> M.D.		22b. DATE SIGNED <u>10-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL S. RODRIGUEZ</u>		22d. ADDRESS <u>1424 Old Sulphur Spring Rd. Baltimore</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whitestone Me. Ch. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Whitestone Va.</u>
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u> ADDRESS <u>6500 York Rd. Balto., Md. 21212</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

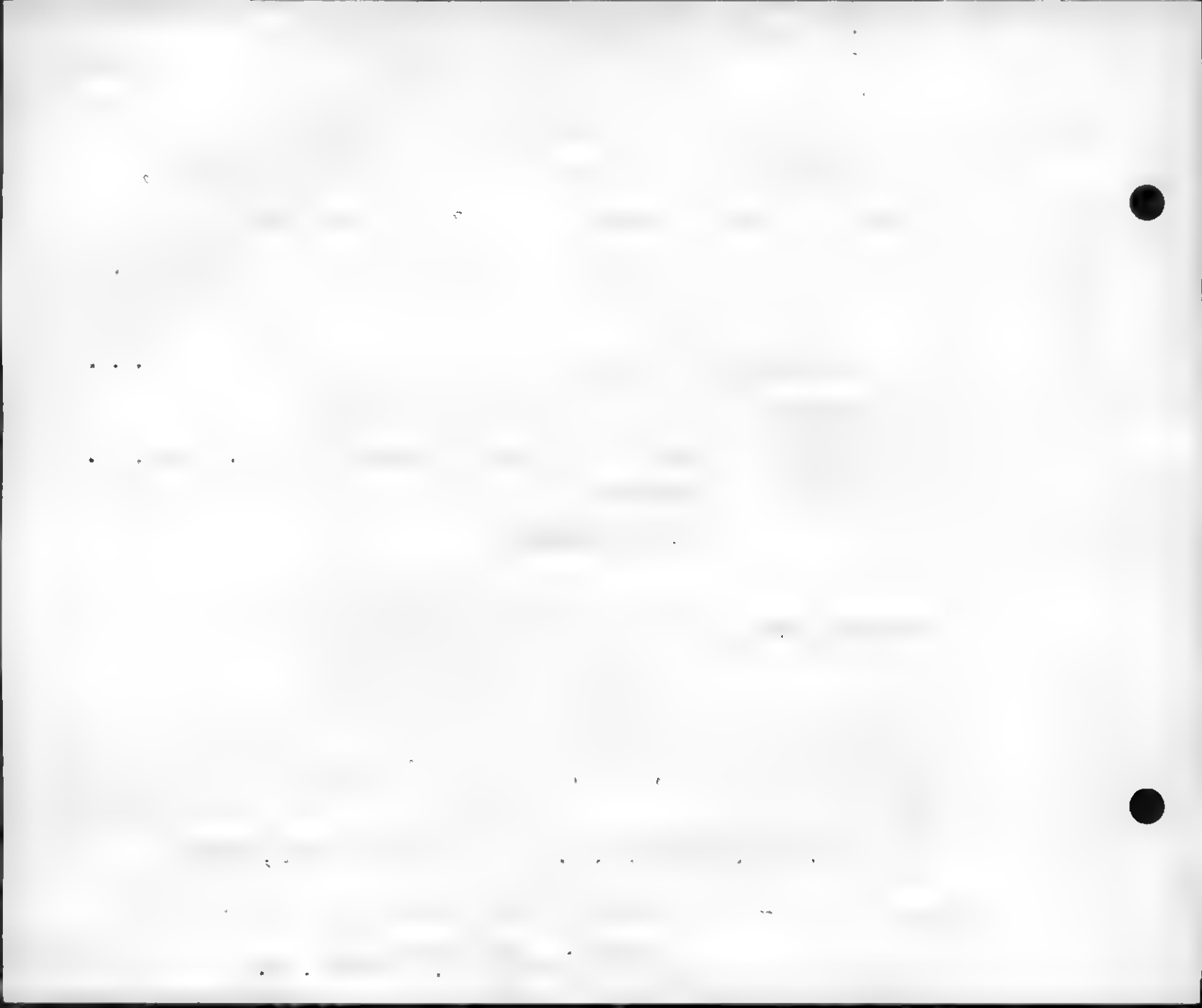


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
13624											
1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c LENGTH OF STAY IN 1b 20 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE # 21224					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL						d. STREET ADDRESS 417 SOUTH DREW STREET				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last SLITZER						4. DATE OF DEATH Month OCTOBER Day 8 Year 1967					
5 SEX MALE		6 COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4/3/94		9. AGE (In years last birthday) yrs 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of work no life, even if retired) FIREMAN, BALTO. CITY				10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND				12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SLITZER						14. MOTHER'S MAIDEN NAME MARY VAN HEEN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI				16. SOCIAL SECURITY NO. 217 38 57 65		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO RHABDOMYOSARCOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21 I certify that the (this hospital) attended the deceased from SEPT 18, 1967 to OCT 8, 1967 , that he (we) last saw the deceased alive on OCT 8, 1967 , and that death occurred at 11:45 PM , from causes and on the date stated above.											
22a. SIGNATURE <i>John D. Talbert</i>						MD ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/10/67			
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.						22d. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-13-67.		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEMETERY				23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR <i>Charles S. Zeiler</i>				ADDRESS CHARLES S. ZEILER FUNERAL HOME				25a. REC'D BY REGISTRAR 13		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				6200 BLK EASTERN AVE. BALTIMORE, MD.				1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

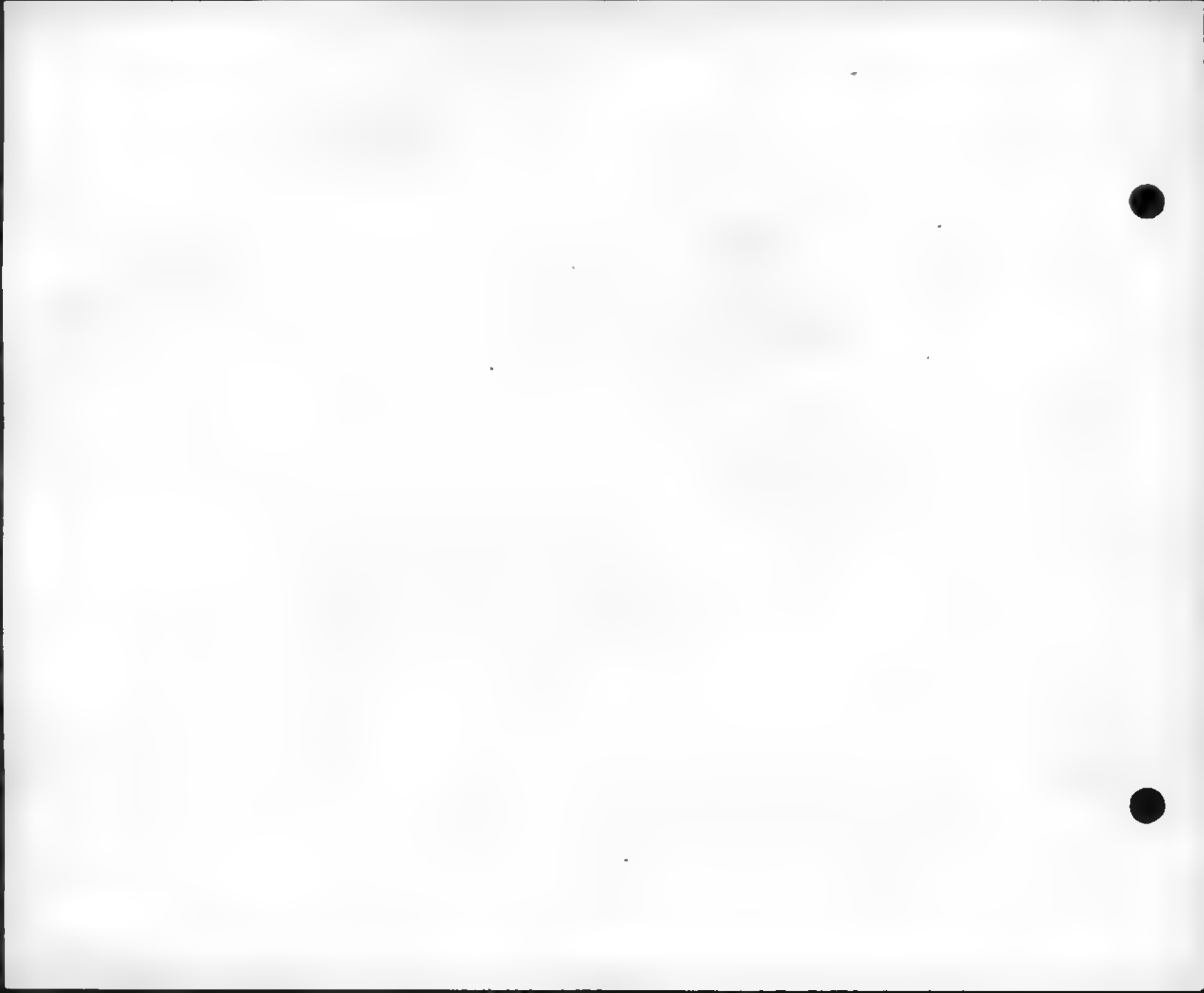
CERTIFICATE OF DEATH

13625

13619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY J	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Kingsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204		d. STREET ADDRESS Cedar Lane	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last SMETANA		4. DATE OF DEATH Month October Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 1 Days 29 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co. Baltimore	
11. BIRTHPLACE (County & State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? Baltimore	
13. FATHER'S NAME Anthony J. Smetana		14. MOTHER'S MAIDEN NAME Frances Solar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give what or dates of service) 1		16. SOCIAL SECURITY NO. 212-05-5588	
17. INFORMANT Marie A. Smetana - Cedar Lane - Kingsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO (b) Paralytic ileum DUE TO (c) Left ureteral calculi with chronic pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10-28 , 1967, to 10-29 , 1967, that (we) last saw the deceased alive on 10-29 , 1967 and that death occurred at 9:15AM , from causes and on the date stated above.			
22a. SIGNATURE William		22b. DATE SIGNED 10-29-67	
22c. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-2-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR John C. Allen Inc. - 715 N. Main St. - 21206		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13626

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson				c. LENGTH OF STAY IN 1b 192 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS 3118 W. Saratoga St.			
3. NAME OF DECEASED (Type or print) First Clarence Middle Edward Last Smith				4. DATE OF DEATH Month Oct Day 21 Year 1967			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-02		9. AGE (In years last birthday) 65 yrs	10. IF UNDER 1 YEAR Months 6 Days 21 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Mary Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 220-09-0981		17. INFORMANT Records at Mt. Wilson State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Myocardial infarct DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pulmonary tuberculosis							INTERVAL BETWEEN ONSET AND DEATH 2-3 mos 4 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-12 , 19 67 , to 10-21 , 19 67 , that (I) (we) last saw the deceased alive on 10-20 , 19 67 , and that death occurred at 5:45 A M, from causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				22b. DATE SIGNED 10-21-67		22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.	
22d. ADDRESS Mount Wilson, Maryland				22e. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-25-67		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR MORTON & Dye II				25a. REC'D BY REGISTRAR 1701 LAURENS		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **Funeral** please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

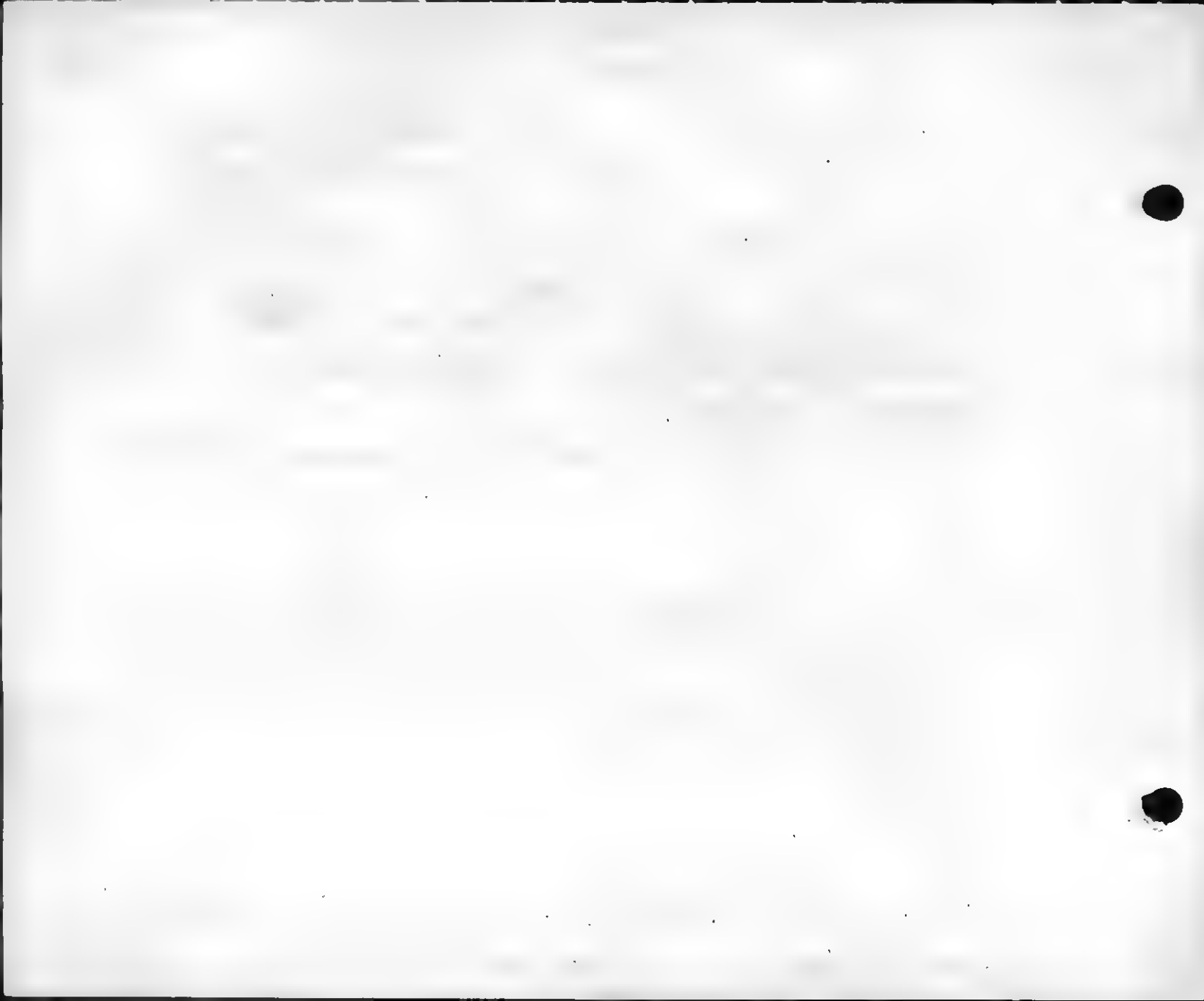


1
FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13627

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		d. STREET ADDRESS <u>Wiseburg Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wiseburg Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert MILTON SMITH</u>	4. DATE OF DEATH <u>Oct 28</u> 19 <u>67</u>	5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Dec 13 1904</u>	9. AGE (In years last birthday) <u>62</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman Railroad</u>	
11. BIRTH PLACE (State or foreign country) <u>Bentley Springs, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel C. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Reba Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-12-3356</u>	
17. INFORMANT <u>Mary F. Smith</u>		Address <u>White Hall, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 7-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		22. DATE SIGNED <u>10/29/67</u>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Oct 31 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Freeland, Md.</u>
24. FUNERAL DIRECTOR <u>Dr. Karlsten, New Freedom, Pa</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>William Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.

Health prior to burial, cremation, or removal, and n any event within 72 hours after death

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #10b & 16 from #1004 01/15/67 ch
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item #14 per death cert. w/ funeral home

Item #14 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13628

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herman O. Smith		4. DATE OF DEATH Month 10 Day 28 Year 1967	
5. SEX Male	6. CO. OR RACE Ca	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1912
9. AGE (In years last birthday) 55 yrs		10. US. AL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Forman	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ira M. Smith		14. MOTHER'S MAIDEN NAME Sara I. Swanner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-9300	
17. INFORMANT Mrs. Doris B. Smith		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: Coronary Occlusion Sudden Coronary Insufficiency 8/10	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVIEW BETWEEN ONSET AND DEATH	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes		22. DATE SIGNED 10/28/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-1967	
23c. NAME OF CEMETERY OR CREMATORY Fork Meth Cemetary		23d. LOCATION (City or Town) (County) (State) Fork Md.	
24. FUNERAL DIRECTOR Joseph J. ...		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
25b. REGISTRAR'S SIGNATURE Charles J...		26. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician. Page 2 of 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

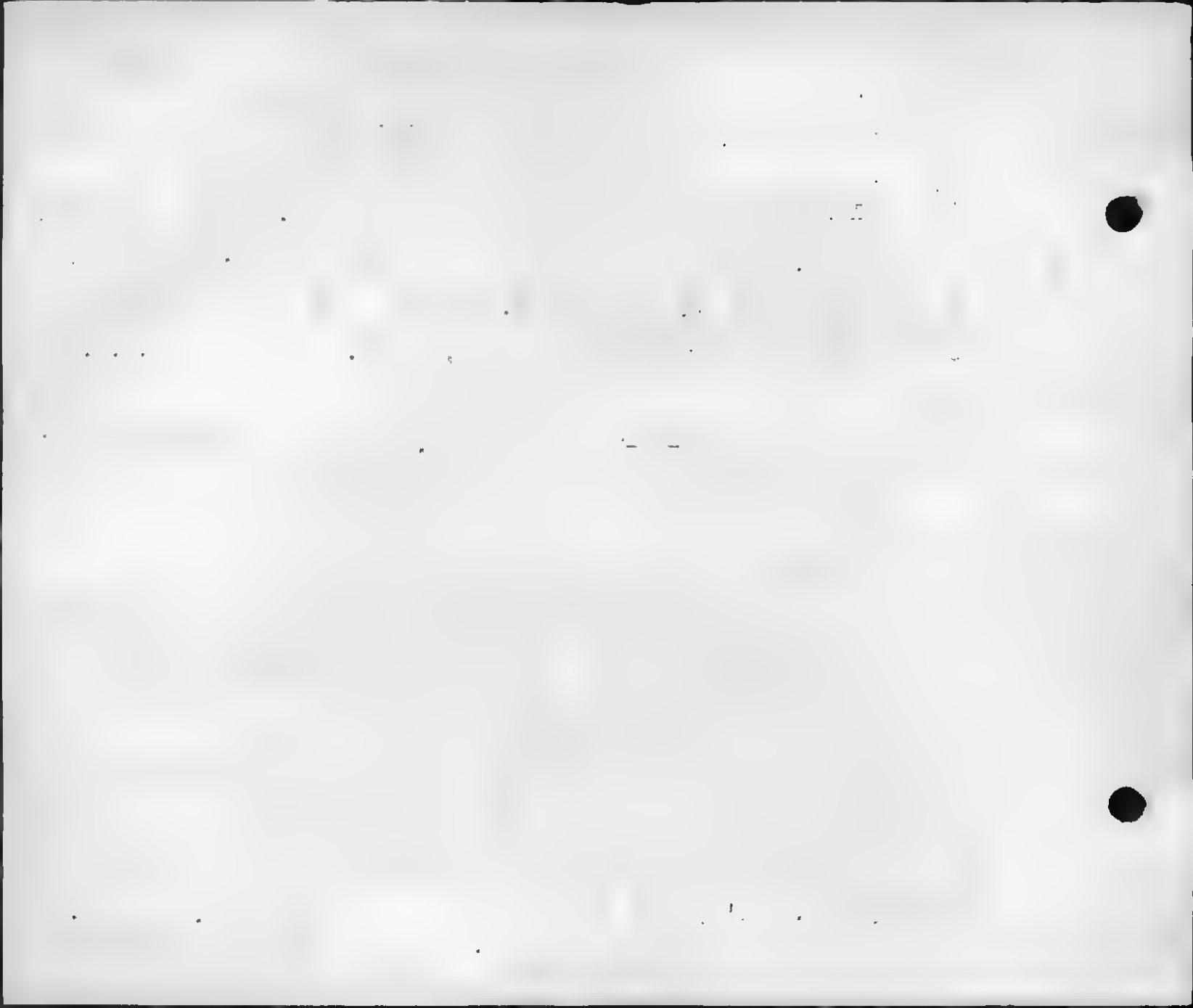
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13629

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4411 Wilkens Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 4411 Wilkens Ave.	
3. NAME OF DECEASED (Type or print) Mary S. Smith		4. DATE OF DEATH Month Oct. Day 24 , Year 1967	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1870
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (County & State, or foreign country) York, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mohr		14. MOTHER'S MAIDEN NAME Rosenberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-07-7651A	
17. INFORMANT Ethel M. Frechette		Address 4411 Wilkens Ave. Arbutus	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 1963 to Oct 24 , 1967, that (I) (we) last saw the deceased alive on Oct 24 , 1967, and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John F. Coolahan M.D.		22b. DATE SIGNED 10/24/67	
22c. PHYSICIAN'S NAME (Type) JOHN F. COOLAHAN, M.D.		22d. ADDRESS 4201 WILKENS AVE - 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27, '67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marie M. Walters		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Pratt & Stricker Sts. Baltimore City		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 27 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 23a & 23b File # 0393 10/20/67 kdc

13630

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204 c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home				2. USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE Maryland b. COUNTY Baldwin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin d. STREET ADDRESS Baldwin Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Merriett T. Smith				4. DATE OF DEATH NOV 11 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1881	
9. AGE (In years last birthday) 86 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (County & State, or foreign country) Pt. Deposit, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Truman Smith			
14. MOTHER'S MAIDEN NAME Joanne Dixon				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO 161-284562				17. INFORMANT Dulaney Towson Nursing Home, 111 West Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) - Hypertensive cardiovascular disease (c) and cerebral vascular accident.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from September 2, 1965 , to 10-11 , 1967, that (I) (we) last saw the deceased alive on 10-10 , 1967, and that death occurred at 845 M, from causes and on the date stated above							
22a. SIGNATURE Mary L. McCorkle				M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22b. DATE SIGNED Oct 11 1967				22c. PHYSICIAN'S NAME (Type) ARCHER FUNERAL HOME			
22d. ADDRESS BENSON, MD.				22e. REC'D BY REGISTRAR OCT 17 1967			
22f. REGISTRAR'S SIGNATURE Charles Judge				23a. BURIAL CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Oct. 14, 1967				23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial			
23d. LOCATION (City or Town) (County) (State) Bel Air Md				23e. LOCATION (City or Town) (County) (State) Bel Air Md			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12625

CERTIFICATE OF DEATH

13631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampton</u> <u>21204</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center.</u>		d. STREET ADDRESS <u>1214 Culvert Rd.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Maude Gertrude Snyder.</u>		4. DATE OF DEATH Month Day Year <u>10 14 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-17-79</u> AGE (In years last birthday) <u>88</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11 BIRTHPLACE (County & State, or foreign country) <u>GUFFY-Penna.</u>
13. FATHER'S NAME <u>Albert Clyde Snyder.</u>		14. MOTHER'S MAIDEN NAME <u>Wm. H. Jones Rachel Corsin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>218-36-3403</u>	17 INFORMANT Address <u>Henry W. Jones, Same as # 2</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular disease accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic cardiovascular disease.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10.7.67</u> , 19 <u>67</u> , to <u>10.14.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10.13.67</u> 19 <u>67</u> , and that death occurred at <u>5:04</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Dipak Kumar Mallik</u>		22b. DATE SIGNED <u>10.14.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DIPAK KUMAR MALLIK</u>		22d. ADDRESS <u>Greater Baltimore Medical Centre.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Dorsey, Howard Co., Maryland</u>
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</u>		25a. REC'D BY REGISTRAR <u>OCT 17 1967</u>	25b REGISTRAR'S SIGNATURE <u>Johnas Judge</u>

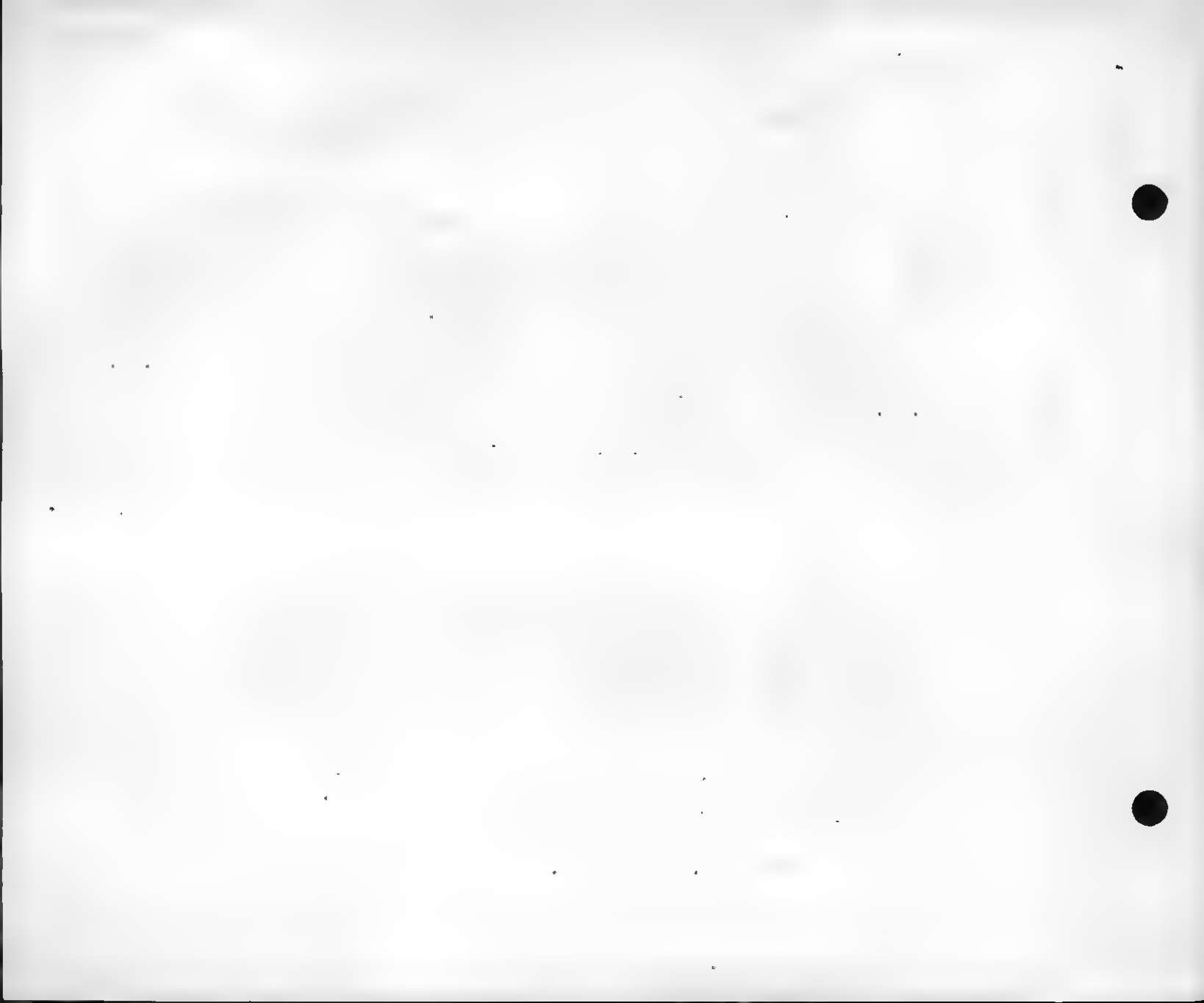
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13632

CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN b 12yr5mth14dys	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e STREET ADDRESS 4014 STARBROOK ROAD 3806XXXXXXXXXXXXXX RANDALLSTOWN	
3 NAME OF DECEASED (Type or print) First Rose Middle XXXXXXXXXX Last Sofronsky		4 DATE OF DEATH Month October Day 23 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Sept. 1900
9 AGE (in years last birthday) yrs 67		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY AT HOME	
11 BIRTHPLACE (County & State, or foreign country) Russia		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME RABBI MENACHUM N. WEISBLATT XXXXXXXXXXXXXXXXXXXX		14 MOTHER'S MAIDEN NAME Hannah XXXXXXXX ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 219-54-3435	
17 INFORMANT MRS. SADIE RAY LONDON, 4014 STARBROOK RD XXXXXXXXXXXXXXXXXXXX STATE XXXXXXXX		Address 21133	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal ileitis 3120 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 wks.
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from April 11, 1955 to Oct. 23 1967 , that (he) (we) last saw the deceased alive on Oct. 23, 19 67 , and that death occurred at 2:55 M, from causes and on the date stated above.			
22a SIGNATURE Anthony J. Young, M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b DATE SIGNED 10-23-67
22c PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 10-24-67	23c NAME OF CEMETERY OR CREMATORY OHR KNESSETH ISRAEL ANSHE SEARD, BALTIMORE, MARYLAND	23d LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		25a REC'D BY REG STRAR OCT 27 1967	25b REGISTRAR'S SIGNATURE Charles Jodge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



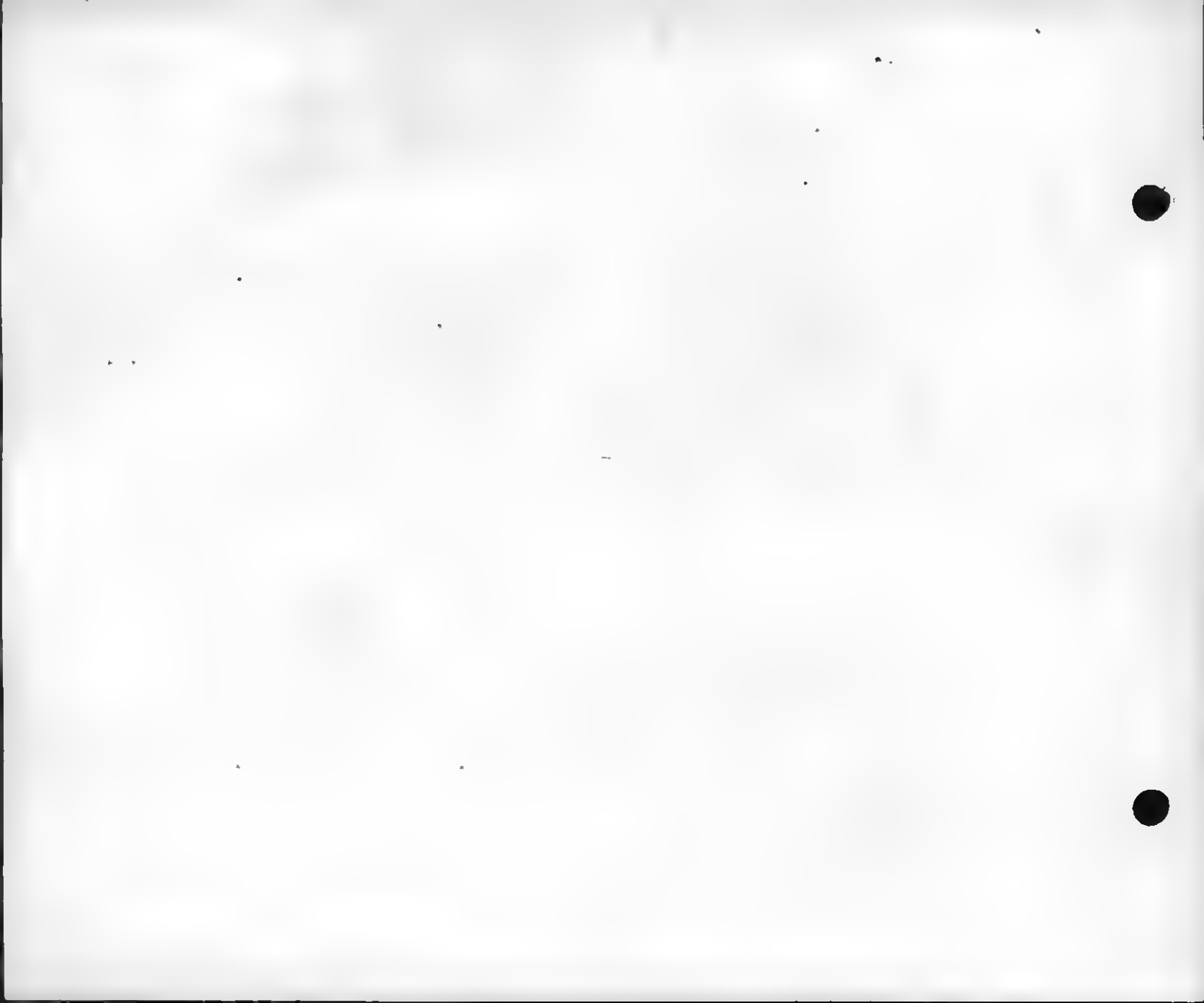
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13633

1 PLACE OF DEATH a. COUNTY Baltimore, County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Md. 21228				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 4104 Mountwood Road 21229			
3 NAME OF DECEASED (Type or print) Dallas Org Southworth				4 DATE OF DEATH Oct. 8, 1967			
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1885	9 AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Battery man		10b KIND OF BUSINESS OR INDUSTRY Retired - Self		11. BIRTHPLACE (County & State, or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Henry Southworth				14. MOTHER'S MAIDEN NAME Lucretia ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 216-10-8770		17. INFORMANT Address Spring Grove Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis & Calcium in Arteries DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1967 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on OCT 8 1967 , and that death occurred at 7 P M, from causes and on the date stated above.							
22a SIGNATURE Robert Fisher				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 10/8/67	
22c. PHYSICIAN'S NAME (Type) Robert Fisher				22d. ADDRESS Spring Grove State Hospital			
23a BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b DATE THEREOF 10/12/67		23c NAME OF CEMETERY OR CREMATORY Loydon Pk.		23d LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR JOHN T. STANSBURY				ADDRESS 4111 WINDSOR MILL RD. BALTO.		25a. REC'D BY REGISTRAR DATE OCT 11 1967	
				25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13623

CERTIFICATE OF DEATH

13634

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney	
c. LENGTH OF STAY in b 8 years		d. STREET ADDRESS 2410 Harwood Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2410 Harwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward H. Spence First Middle Last		4. DATE OF DEATH Oct. 1 1967 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1924
9. AGE (In years last birthday) 42 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (County & State, or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Spence		14. MOTHER'S MAIDEN NAME Margaret Cahill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO 93-18-8619	
17. INFORMANT Virginia Spence		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive coronary artery occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1/2 - 1 hr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 , to Sept 23, 1967 , that (I) (we) last saw the deceased alive on Sept 23, 1967 , and that death occurred at 2:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Theodore J. Braziano</i>		22b. DATE SIGNED Oct 3, 1967	
22c. PHYSICIAN'S NAME (Type) Theodore J. Braziano		22d. ADDRESS 2802 Harford Rd 21218	
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE THEREOF Oct. 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR C. F. Evans & Son 8802 Harford Road		25a. REC'D BY REGISTRAR OCT 4 1967	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



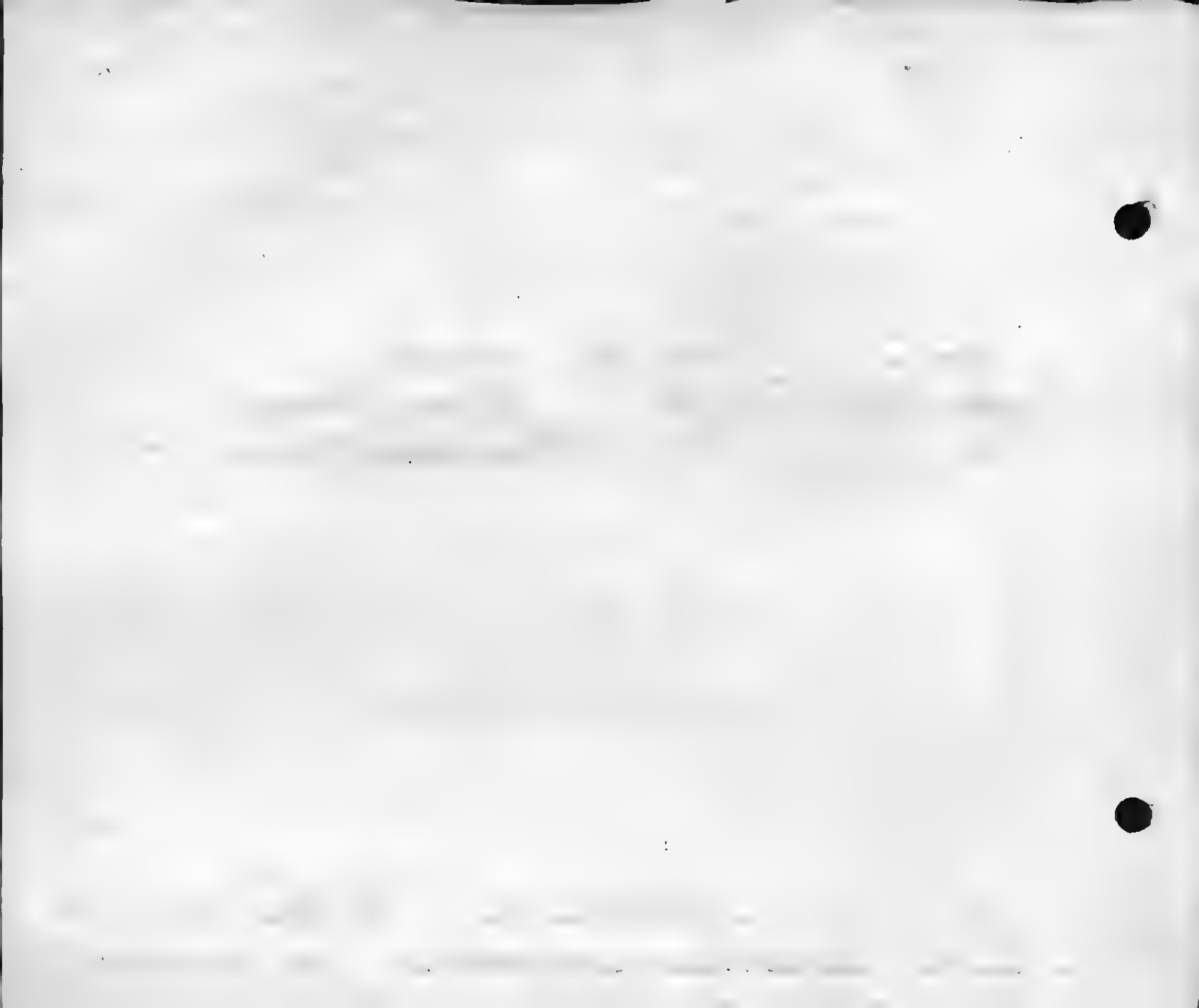
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

13635

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b <u>14 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore County General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> d. STREET ADDRESS <u>3314 Offutt Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence L Stephens</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-83</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. AGE (In years last birthday) <u>83</u> yrs.	11. AGE (In years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weaver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton Mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John William Forsythe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213 037511</u>	
17. INFORMANT <u>Mary Dorothy Meszars</u>		Address <u>3314 Offutt Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident (THROMBOSIS)</u> DUE TO (b) <u>ATHEROSCLEROSIS, GENERALIZED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Unknown</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a.m. <u>20</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> <u>1967</u> to <u>10-24</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> <u>1967</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba</u> M.D.		22b. DATE SIGNED <u>10-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rolando A. Madamba</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>John Charles Jones</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>OCT 30 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13636

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 10 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin d. STREET ADDRESS Allison Dr. Carroll Manor e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD STUDZ First Middle Last		4. DATE OF DEATH Oct. 9 1967 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27 1902 9. AGE (In years lost birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Real Estate & Ins. Md.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Karol Studz		14. MOTHER'S MAIDEN NAME Bertha Rybicki	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-4094	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO (b) Gorman's Porting Disease DUE TO (c) Arteriosclerotic Cardiac Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 54w 84w
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12 Nov 1967 , to 8 Oct 1967 , that (I) (we) last saw the deceased alive on 8 Oct 1967 , and that death occurred at 11A M. from causes and on the date stated above.			
22a. SIGNATURE Howard Goodman		22b. DATE SIGNED 12 Oct 67	
22c. PHYSICIAN'S NAME (Type) HOWARD GOODMAN M.D.		22d. ADDRESS 8604 Harford road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-13-67	23c. NAME OF CEMETERY OR CREMATORY St. John's Long Green	23d. LOCATION (City or Town) (County) (State) Balto Co Md.
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13631

13637

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first tuition Residence before admission) a STATE MARYLAND b COUNTY V	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c LENGTH OF STAY In 3 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST JOSEPH HOSPITAL		e STREET ADDRESS 6232 BELAIR RD	
3 NAME OF DECEASED (Type or print) First JOSEPH Middle SWISS Last SWISS		4 DATE OF DEATH Month OCT Day 24 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT 3 1881
9a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) GROCKER SELF		9b KIND OF BUSINESS OR INDUSTRY RETIRED	
10a BIRTHPLACE (State or foreign country) GERMANY		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13 FATHER'S NAME JOSEPH SWIECZKOWSKY		14 MOTHER'S MAIDEN NAME JOSEPHINE ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 218-18-2034A	
17 INFORMANT ROSE SWISS		Address 6232 BELAIR RD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Fracture of Rt Hip DUE TO Fracture of Rt Hip (c) Fracture of Rt Hip			INTERVAL BETWEEN CORSEP AND DEATH 5 Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH Fall down Steps in back Home		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fall down Steps in back Home	
20c TIME OF INJURY Month, Day, Year 12/19/67 hour am p.m.	20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home	20f (City or town) (County) (State) Baltimore City MD
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		22. DATE SIGNED 12/25/67	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF OCT 27 1967	23c NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM.	23d LOCATION (City or town) (County) (State) GERMAN HILL RD BALTIMORE
24 FUNERAL DIRECTOR THE DIPPEL BROS INC 7110 BELAIR RD.		25a REC'D BY REGISTRAR OCT 26 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO BALDWIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbons 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13532

13638

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Smyth Nursing Home				d. STREET ADDRESS 127 Church Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First May Middle G. Last Talbott				4. DATE OF DEATH Month Oct. Day 24 Year 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/83		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Theo E. Childs				14. MOTHER'S MAIDEN NAME Emma Umstead			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Roland Childs Highland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial Vascular Collapse DUE TO (b) Arteriosclerotic Coronal Vascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-14 , 19 61 , to 10-24 , 19 67 , that (I) we last saw the deceased alive on 10-23 , 19 67 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Herbert M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, MD				22d. ADDRESS Ellicott City, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/26/67		23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION (City, town or county) (State) Ellicott City, Md.	
24. FUNERAL DIRECTOR John R. Slack Hginbelhorn - Slack				ADDRESS Ellicott City Md.		25a. REC'D BY REGISTRAR OATE OCT 27 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13639

13033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN IT _____		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summitt Nursing Home</u>			d. STREET ADDRESS <u>1814 Colonial Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth E. Thalheimer</u>			4. DATE OF DEATH Month Day Year <u>Oct. 10 19 67</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min <u>10 10 10 10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Herman Bennett</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Saffran</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Elizabeth Thalheimer</u> <u>1814 Colonial Rd.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> - 40 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 years</u> <u>years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>TERMINAL BRONCHITIS PNEUMONIA & CHRONIC BRONCHITIS</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 30, 1962</u> , to <u>OCTOBER 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 9, 1967</u> , and that death occurred at <u>3:57 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Melvin N. Borden</u>			22b. DATE SIGNED <u>10/10/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Melvin N. Borden, M. D.</u>			22d. ADDRESS <u>5000 Baltimore National Pike 21224</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
23d. LOCATION (City or Town) <u>Baltimore, Md.</u>		(County) _____ (State) _____			
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Av.</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

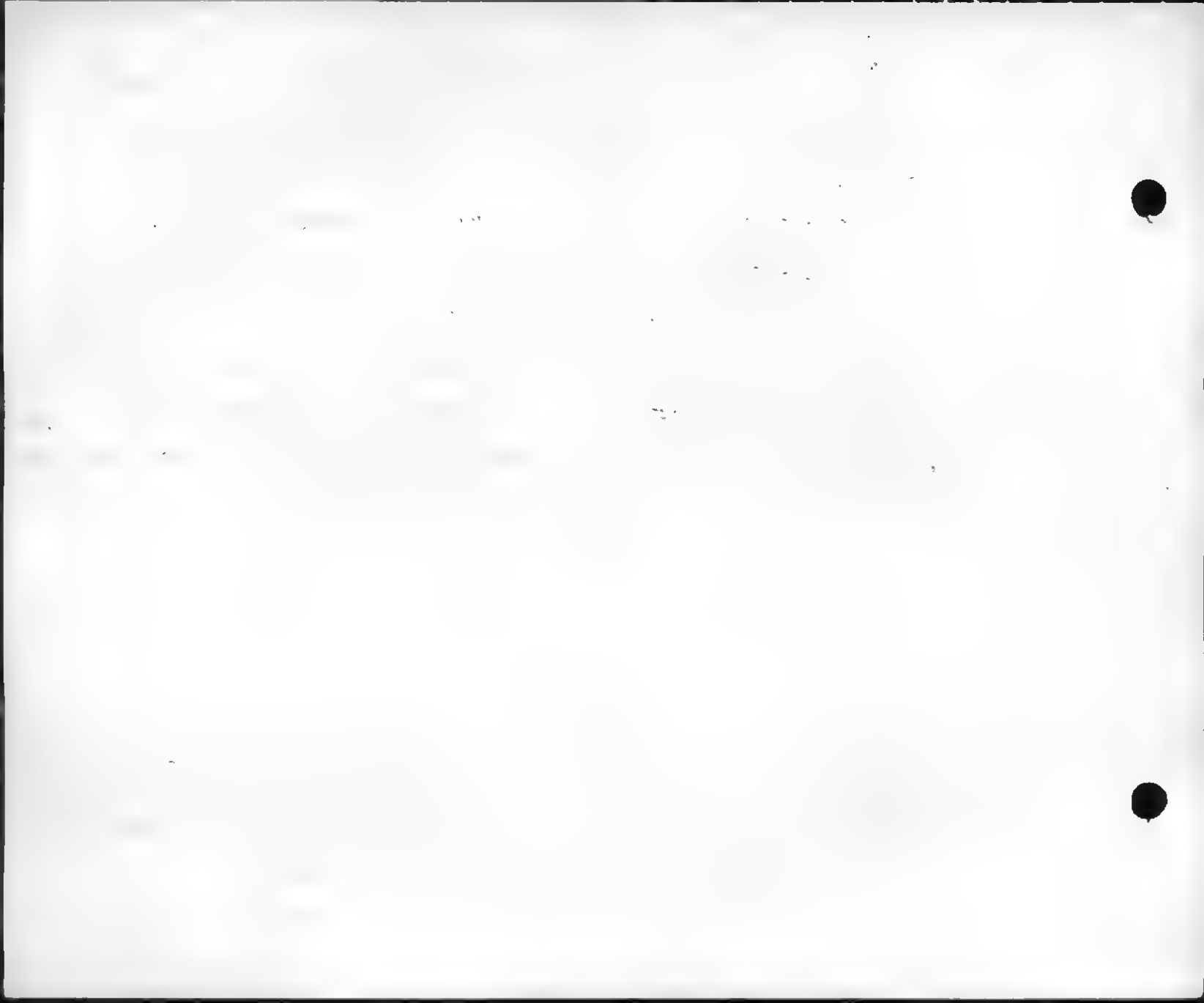
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13640

1 PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 N. WOODWARD DR.				d. STREET ADDRESS 403 N. WOODWARD DR.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BARBARA C. THOMAS				4 DATE OF DEATH OCT 11 1967			
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG. 19, 1884	9 AGE (In years last birthday) 83 yrs	10 UNDER 1 YEAR Months Days Hours Min		11 UNDER 24 HRS Hours Min
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME CHARLES JAMES				14 MOTHER'S MAIDEN NAME PAULINE SCHMIDT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO —		17 INFORMANT Address WM. R. THOMAS JR. 7105 EASTERN AVE.			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Due to (b) Senility (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Gun					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis		EXAMINER'S NAME (Type) M. B. DAVIS M.D. - 6800 M...		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/13/67		23c. NAME OF CEMETERY OR CREMATORY LORRAINE		23d. LOCATION (City or town) (County) (State) BALTO. MD.	
24 FUNERAL DIRECTOR J. G. CONNELLY SONS		ADDRESS 300 MALE		25a. REC'D BY REGISTRAR OCT 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

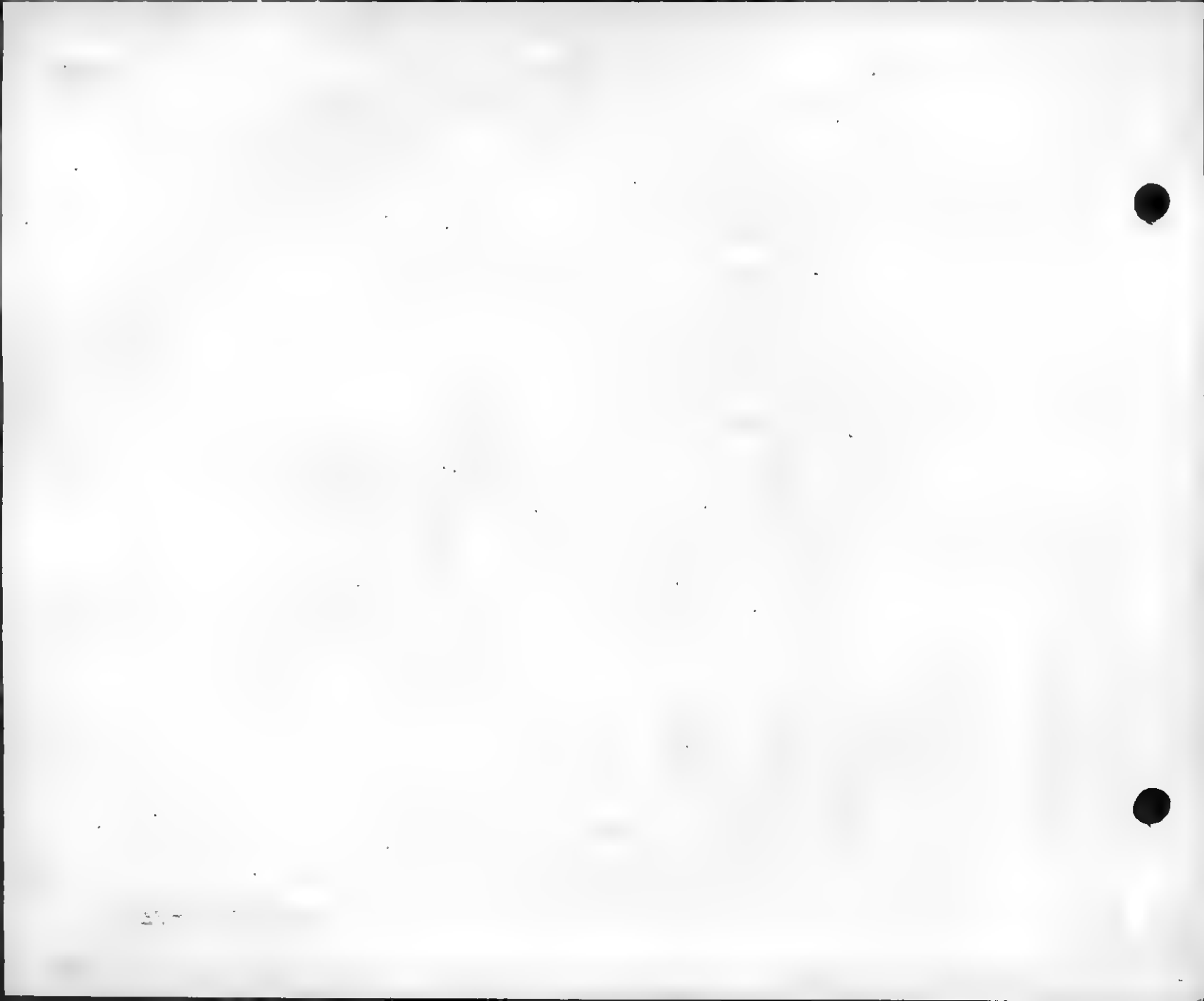
CERTIFICATE OF DEATH

13641

12085

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville, Md.</u> c. LENGTH OF STAY IN <u>8 yrs 6 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) ✓ a. STATE <u>md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u> d. STREET ADDRESS <u>3603 Old York Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>C. LARINDA</u> Middle <u>L. S.</u> Last <u>THOMAS</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1881</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Seipp</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>214-03-5088</u>	
17. INFORMANT <u>Masonic Home Records</u>		Address <u>Masonic Home Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebrovascular accident</u> DUE TO (b) <u>Advanced Senility</u> DUE TO (c) <u>Multiple Atherosclerotic lesions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 15, 1965, to Oct 20, 1967, that (I) (we) last saw the deceased alive on Oct 20, 1967, and that death occurred at 6:30 A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>JAMES H. HAMEL, M.D.</u>		22b. DATE SIGNED <u>10/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMEL</u>		22d. ADDRESS <u>MASONIC HOME</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale</u>	23d. LOCATION (County) <u>Cockeysville, Md.</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>W. Cork-Brooks Towson</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 26 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

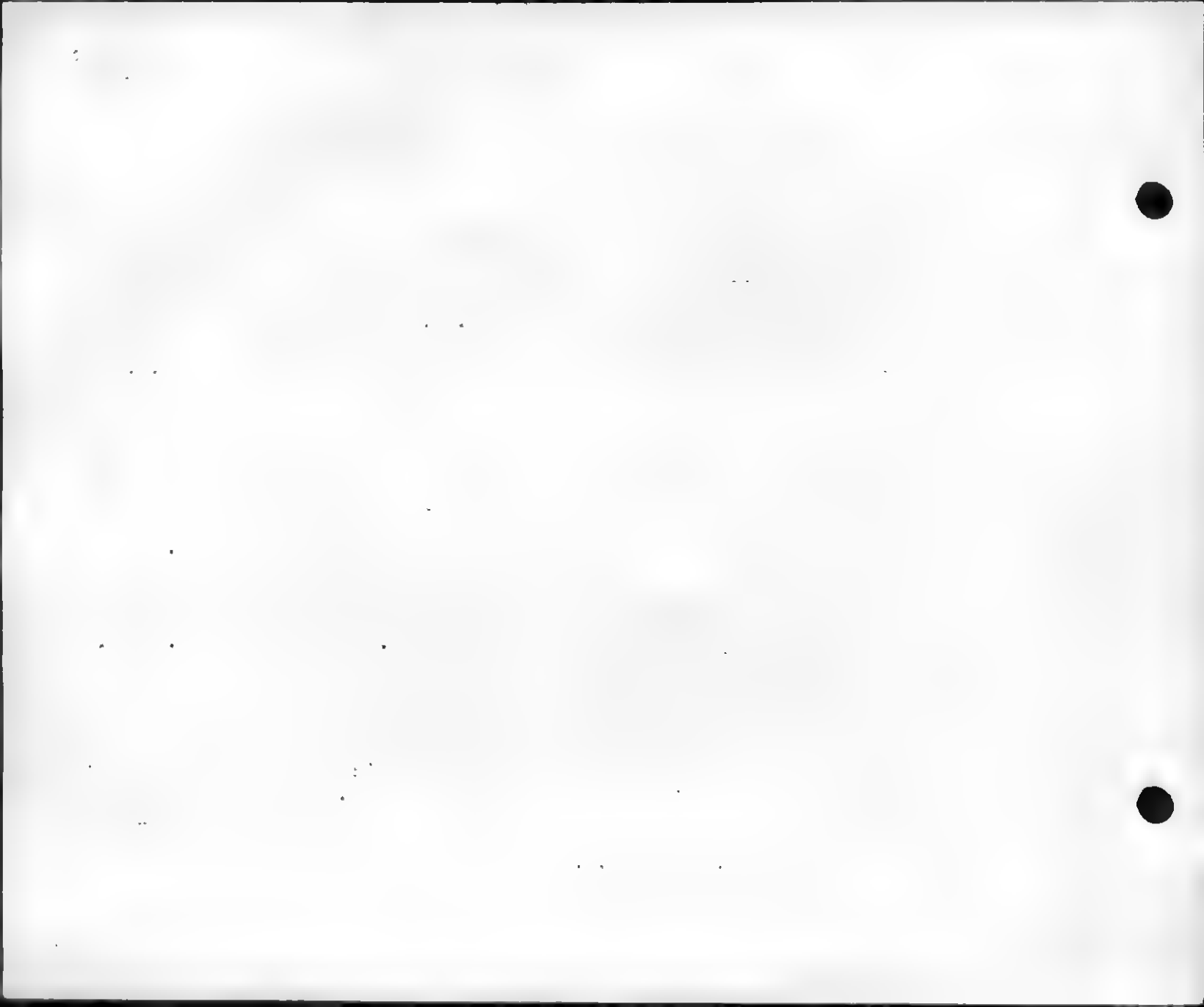
13636

CERTIFICATE OF DEATH

15125

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Maryland c. LENGTH OF STAY in 1b lyr6mty3dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City #21230 d. STREET ADDRESS 1014 Leadenhall Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) George Albert Thomas First Middle Last 5 SEX Male 6 COLOR OR RACE Negro 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH Jan. 3, 1894 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9 AGE (In years last birthday) 73 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12 CITIZEN OF WHAT COUNTRY? U.S.		4 DATE OF DEATH October 21 19 67 Month Day Year 13. FATHER'S NAME Arron Thomas 14. MOTHER'S MAIDEN NAME Martha 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None 16. SOCIAL SECURITY NO 215-03-9787 17 INFORMANT Records: Spring Grove State Hospital Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, diaphragmatic 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular Ht. Dis. DUE TO (c) 10 years INTERVAL BETWEEN ONSET AND DEATH 8		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 18, 1966 to Oct. 21, 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 21 19 67 , and that death occurred at 7:15 P., from causes and on the date stated above. 22a. SIGNATURE <i>Anthony J. Young</i> M.D. 22b. DATE SIGNED 10-23-67 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. 22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 10/28/67 23c. NAME OF CEMETERY OR CREMATORY Nottingham 23d. LOCATION (City or Town) (County) (State) Baltimore City 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> 25c. ADDRESS 25d. DATE NOV 10 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

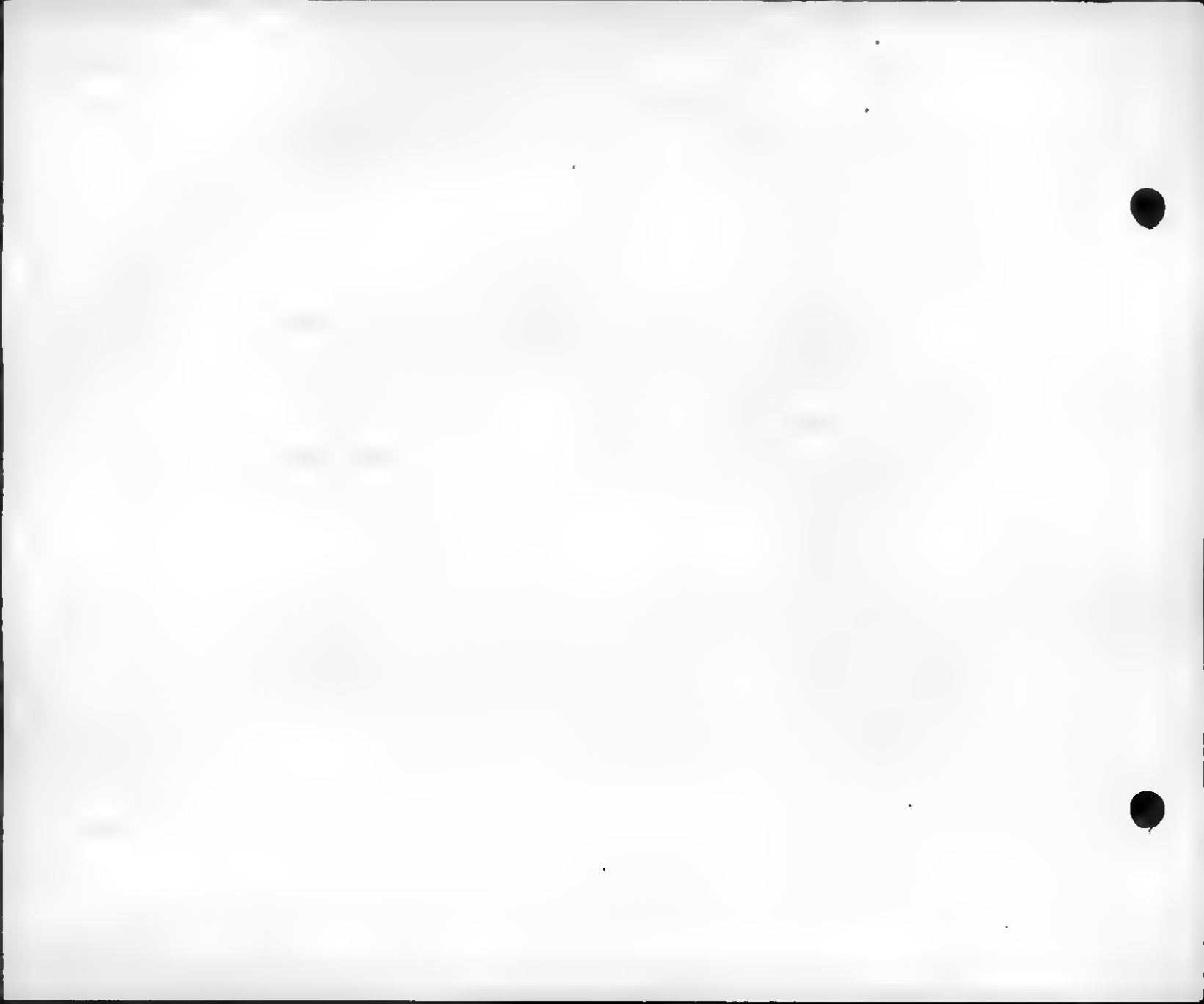
CERTIFICATE OF DEATH

13642

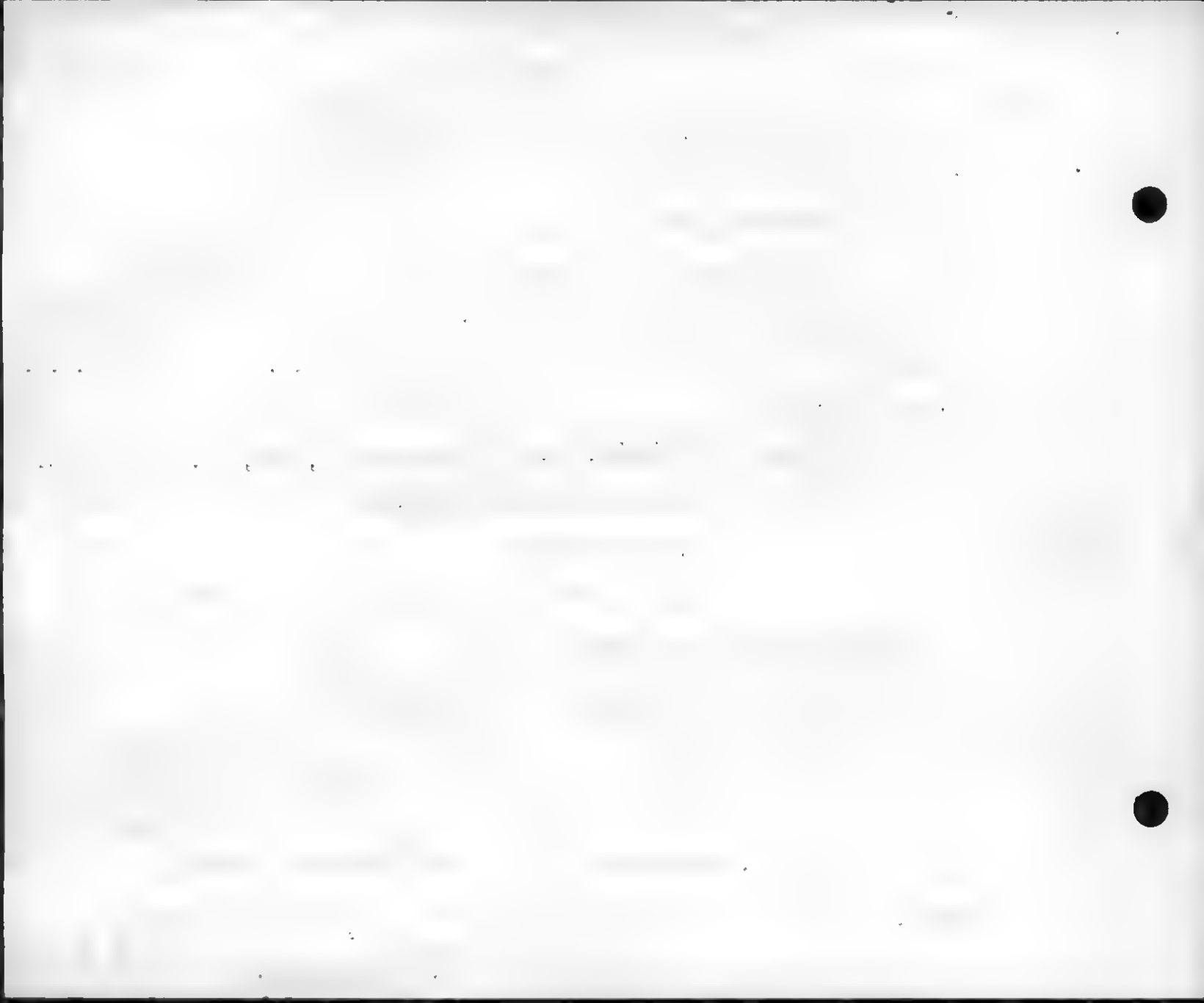
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 446 TUBMAN COURT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMILY Middle THOMPSON Last THOMPSON		4. DATE OF DEATH Month 10 Day 29 Year 1967	
5. SEX F.	6. COLOR OR RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 10 Days 29 Hours 19 Min 67	11. IF UNDER 24 HRS Months 10 Days 29 Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Morris Hill, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Williams		14. MOTHER'S MAIDEN NAME Millie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Records at Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT. 26 , 1967, to OCT. 24 , 1967, that (I) (we) last saw the deceased alive on 19 , and that death occurred at 12:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 10-29-67	
22c. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-1-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cmty.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Randolph J. Collick		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #2c & d filled in #0394 11/2/67 ph

CERTIFICATE OF DEATH

13644

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN It <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21212</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>			d. STREET ADDRESS <u>189 E. Hittings Ave.</u> <u>Pickettsburg Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Amie</u> Middle <u>Townshend</u> Last <u></u>			4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-77</u>		9. AGE (In years last birthday) <u>90</u> yrs IF UNDER 1 YEAR: Months <u></u> Days <u></u> IF UNDER 24 HRS: Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John S. Townshend</u>			14. MOTHER'S MAIDEN NAME <u>Mary ?</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-20-2074</u>		17. INFORMANT <u>Nursing Home Records, Towson, Md. 21204</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>42-1</u> IMMEDIATE CAUSE (a) <u>Chronic Heart Failure</u> DUE TO <u>Arteriosclerosis Cardiac vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular accident</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-25</u> , 19 <u>67</u> , to <u>10-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-20-67</u> , 19 <u>67</u> , and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Jose M. De Leon, M.D.</u>		22b. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>		22c. ADDRESS <u>10-26-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 30, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
23d. LOCATION (City or Town) <u>Woodlawn, Baltimore, Md.</u>		23e. LOCATION (County) (State) <u></u>		23f. LOCATION (County) (State) <u></u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

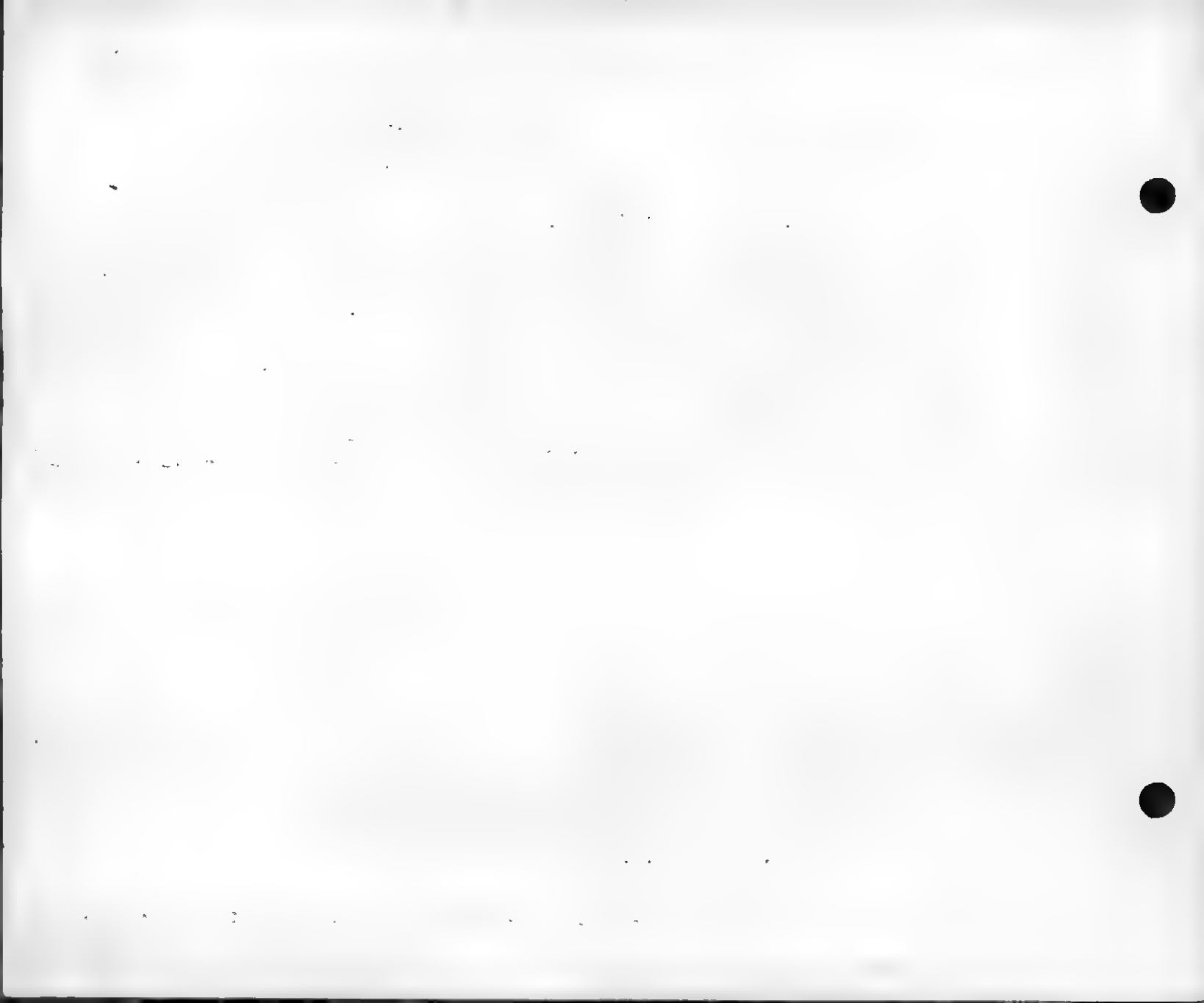
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13640

13645

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY —	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c LENGTH OF STAY IN 1b 30-1	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sue Avenue - S. of Turkey Point Rd.		d STREET ADDRESS 1632 N. Bond St.	
3 NAME OF DECEASED (Type or print) GUY		4 DATE OF DEATH October 30, 19 67	
5. SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-2-19 25
9 AGE (In years lost birthday) yrs 42		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b KIND OF BUSINESS OR INDUSTRY Cabs	
11 BIRTHPLACE (State or foreign country) Tillar, Ark		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME GUY TUCKER		14 MOTHER'S MAIDEN NAME IONIA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW#2		16 SOCIAL SECURITY NO 432-34-5745	
17 INFORMANT ANNIE TUCKER		Address 1632 N. Bond St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO (b) 7011 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Apparently shot during robbery	
20c TIME OF INJURY Month Day Year UNK 10/30/67		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street		20f (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 10/31/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL, (Specify)	23b DATE THEREOF 11/3/67	23c NAME OF CEMETERY OR CREMATORY BALTIMORE NAT. CEM.	23d LOCATION (City or Town) (County) (State) 5501 Fred'k Ave.
24. FUNERAL DIRECTOR Milton E. E. E. E. E.		25a REC'D BY REGISTRAR NOV 1 1967	
25b REGISTRAR'S SIGNATURE John J. Judge			



13641

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

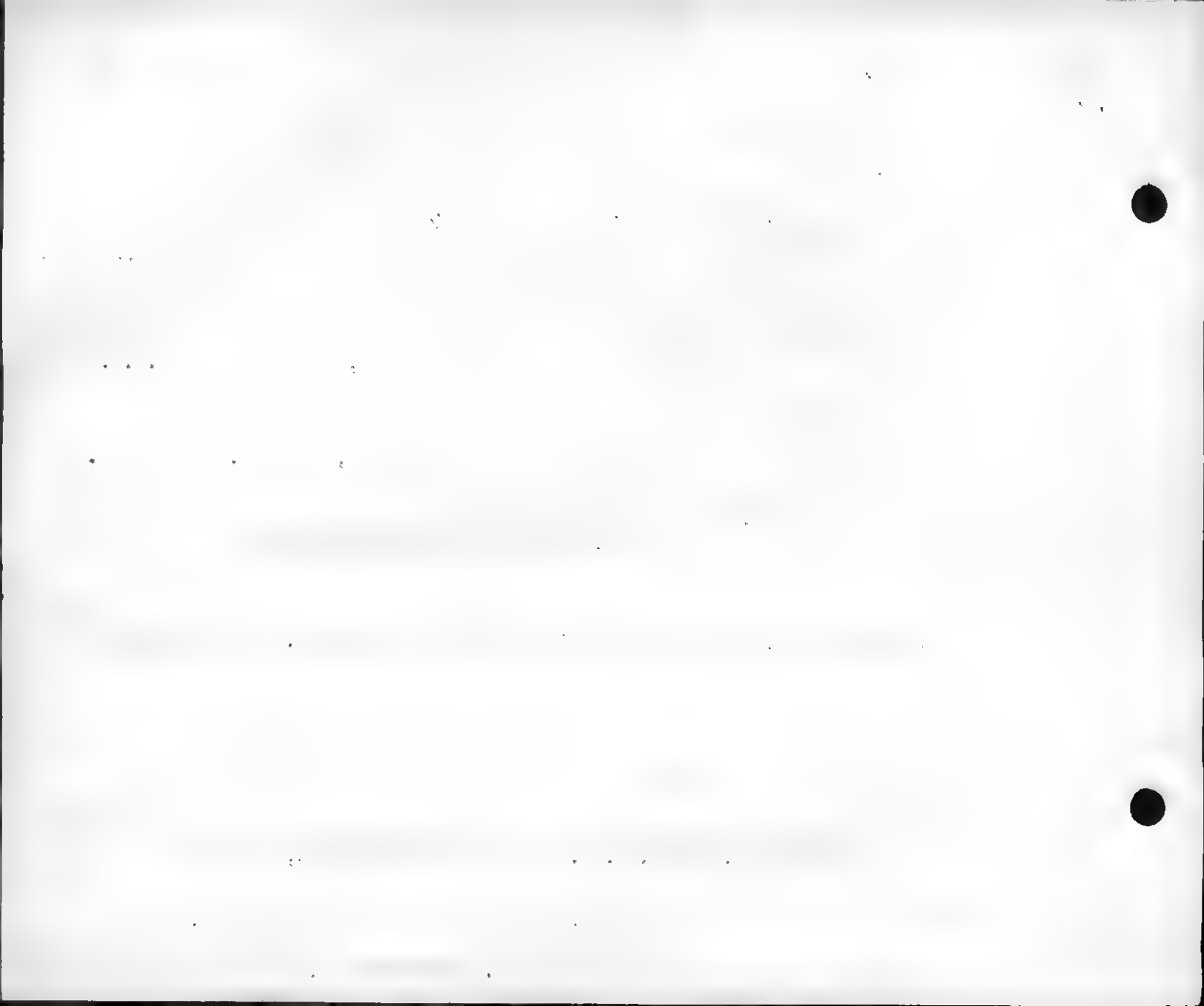
CERTIFICATE OF DEATH

13646

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 86 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d STREET ADDRESS 5207 IVANHOE AVENUE	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle CHRISTOPHER Last VALENTINE		4 DATE OF DEATH Month OCTOBER Day 15 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/23/98
9 AGE (In years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10b KIND OF BUSINESS OR INDUSTRY MEAT	
11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME CONRAD VALENTINE		14 MOTHER'S MAIDEN NAME HANNAH BACHMANN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16 SOCIAL SECURITY NO 213 10 34 73	
17 INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DOE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) POST OPERATIVE STATUS POST PROSTECTOMY DOE TO (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL SCARRING. ENCEPHALOMALACIA		19 WAS AUTOPSY PERFORMED? NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 7/23/67 , to 10/15/67 , 19 67 , that he (we) last saw the deceased alive on 10/15/67 , 19 67 , and that death occurred at 7:20AM from causes and on the date stated above			
22a SIGNATURE JOSEPH J. MOWAD, M. D.		22b DATE SIGNED 10/16/67	
22c PHYSICIAN'S NAME (Type) JOSEPH J. MOWAD, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 10-19-67	
23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24 FUNERAL DIRECTOR EVANS FUNERAL HOME		25a REC'D BY REGISTRAR 10/17/67	
25b DATE 10/17/67		25c REGISTRAR'S SIGNATURE J. J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

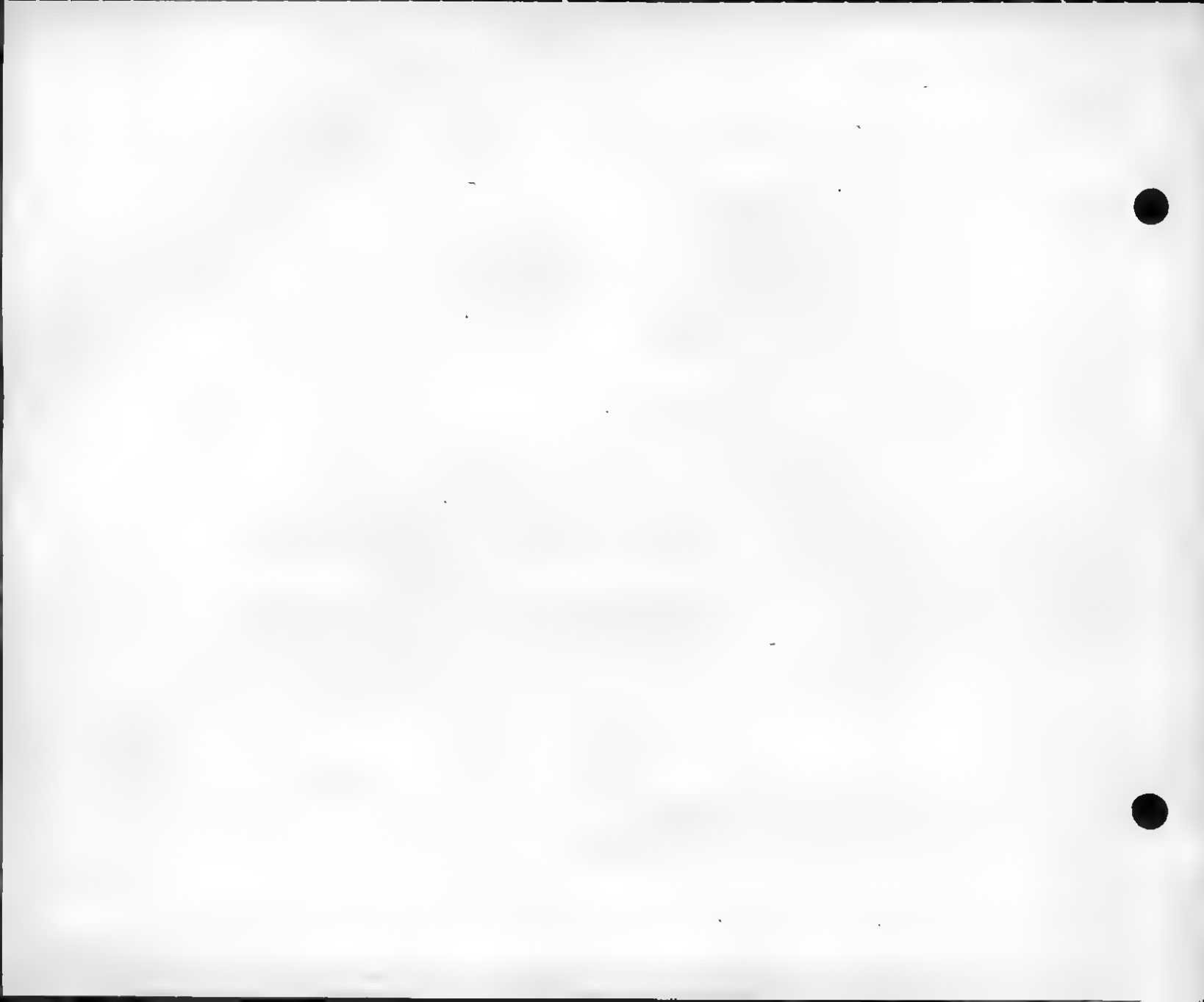
CERTIFICATE OF DEATH

13647

13642

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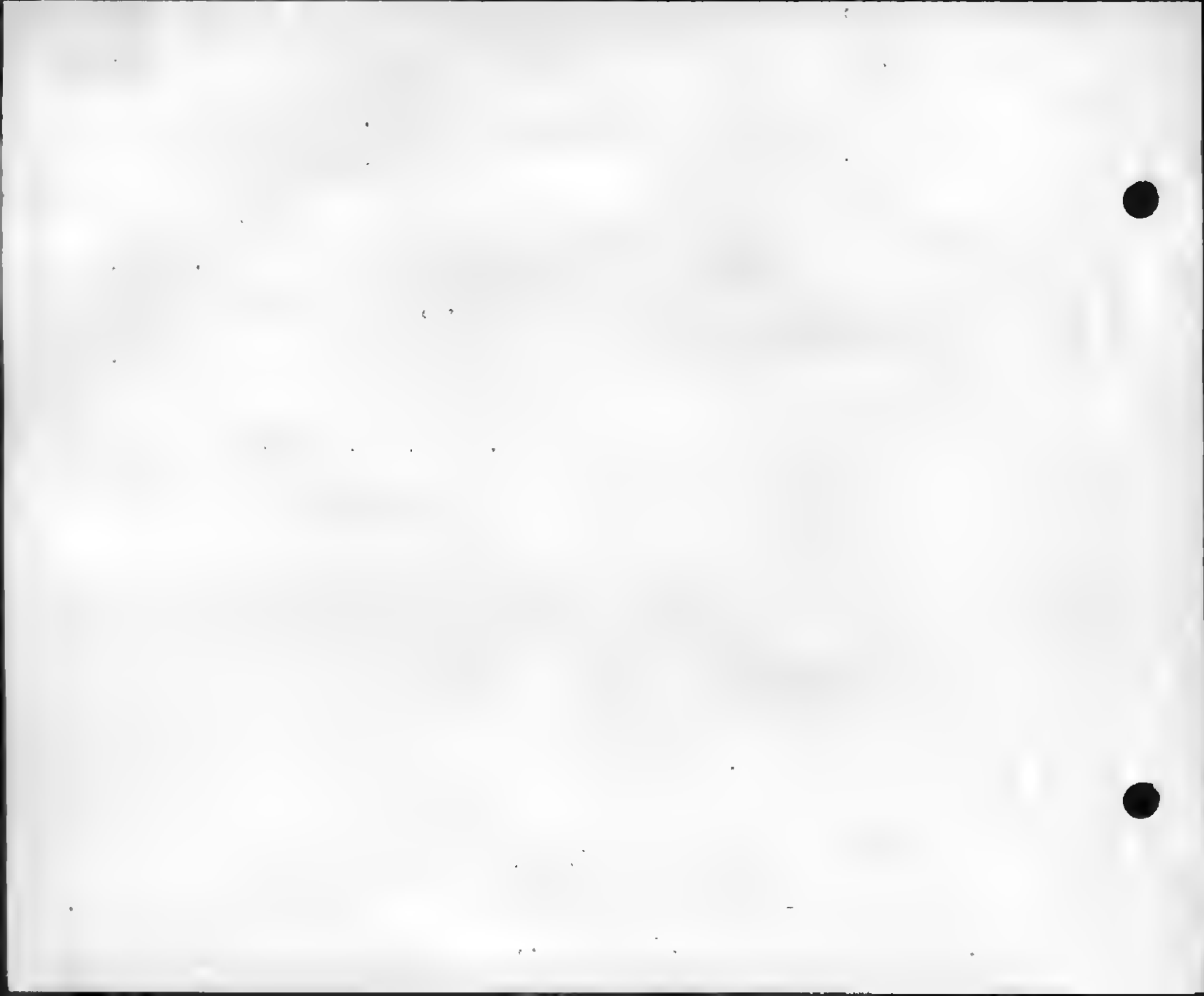
1 PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 281 VANDERMAST LANE		d. STREET ADDRESS 281 VANDERMAST LANE	
3 NAME OF DECEASED (Type or print) First Middle Last MARIE M. VANDERMAST		4 DATE OF DEATH Month Day Year OCT. 31 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1880
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARNOLD VANDERMAST	
14. MOTHER'S MAIDEN NAME ELIZABETH HERR		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO —		17. INFORMANT Address EDNA VANDERMAST ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE 4100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 24 RS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) VIRAL UPPER RESPIRATORY INFECTION			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from SEPT. 23, 1965 , to OCT 31, 1967 , that (I) (we) last saw the deceased alive on OCT 30, 1967 , and that death occurred at 11:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Joseph Miceli		22b. DATE SIGNED 11/1/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH MICELI, M.D.		22d. ADDRESS 108 S. TAYLOR AVE. ESSEX, MD. 21221	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE	23d. LOCATION (City or Town) (County) (State) BALTO. MD.
24. FUNERAL DIRECTOR J. S. CONNELLY SONS		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13643 Item #23b,c & d File #6593 10715757 ph									
13648									
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Benardus Middle Van Der Wensch Last Oct.					4. DATE OF DEATH Month 16 Day 19 Year 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3, 1878		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO.				
17. INFORMANT Mrs. Lucille D. Weyrauch					Address 3508 Jean Drive				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/6 , 19 67 to 10/16 , 19 67 , that (I) (we) last saw the deceased alive on 10/9 , 19 67 , and that death occurred at 1:45 M, from the causes and on the date stated above.									
22a. SIGNATURE Robert A. Reiter					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/67		
22c. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.					22d. ADDRESS 606 Edmonstone Ave 212 28				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THERE 10-18-1967		23c. NAME OF CEMETERY OR CREMATORY Camp Chapel Beth Church		23d. LOCATION (City, town or county) (State) Brooklyn/ Md.		
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,					25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

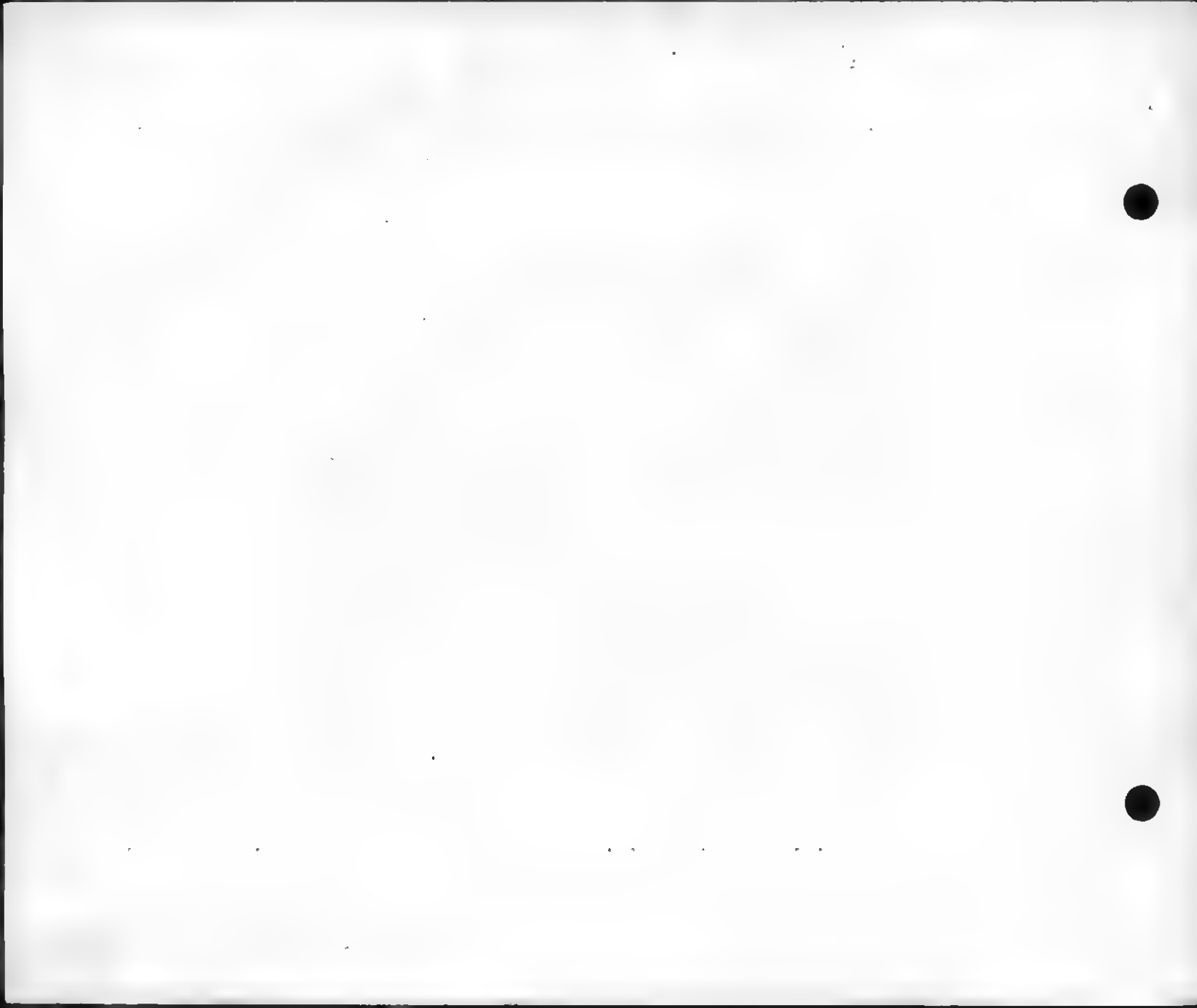
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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13649

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>804 Stevenson Lane</u>				e. STREET ADDRESS <u>804 Stevenson Lane</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Genevieve Freeman Walck</u>				4. DATE OF DEATH Month Day Year <u>October 14 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1896</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Freeman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Barrett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Family records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>234X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>66</u> , to <u>October 14</u> 19 <u>67</u> , that (1) (was) last saw the deceased alive on <u>June 10</u> 19 <u>67</u> , and that death occurred at <u>7 a</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>A. J. Venable, Jr. M.D.</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>10-16-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>S. J. Venable, Jr. M.D.</u>		22d. ADDRESS <u>7215 York Road, Baltimore, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Paxtang Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Paxtang Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>John Burns Sons Funeral Home</u> ADDRESS				25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



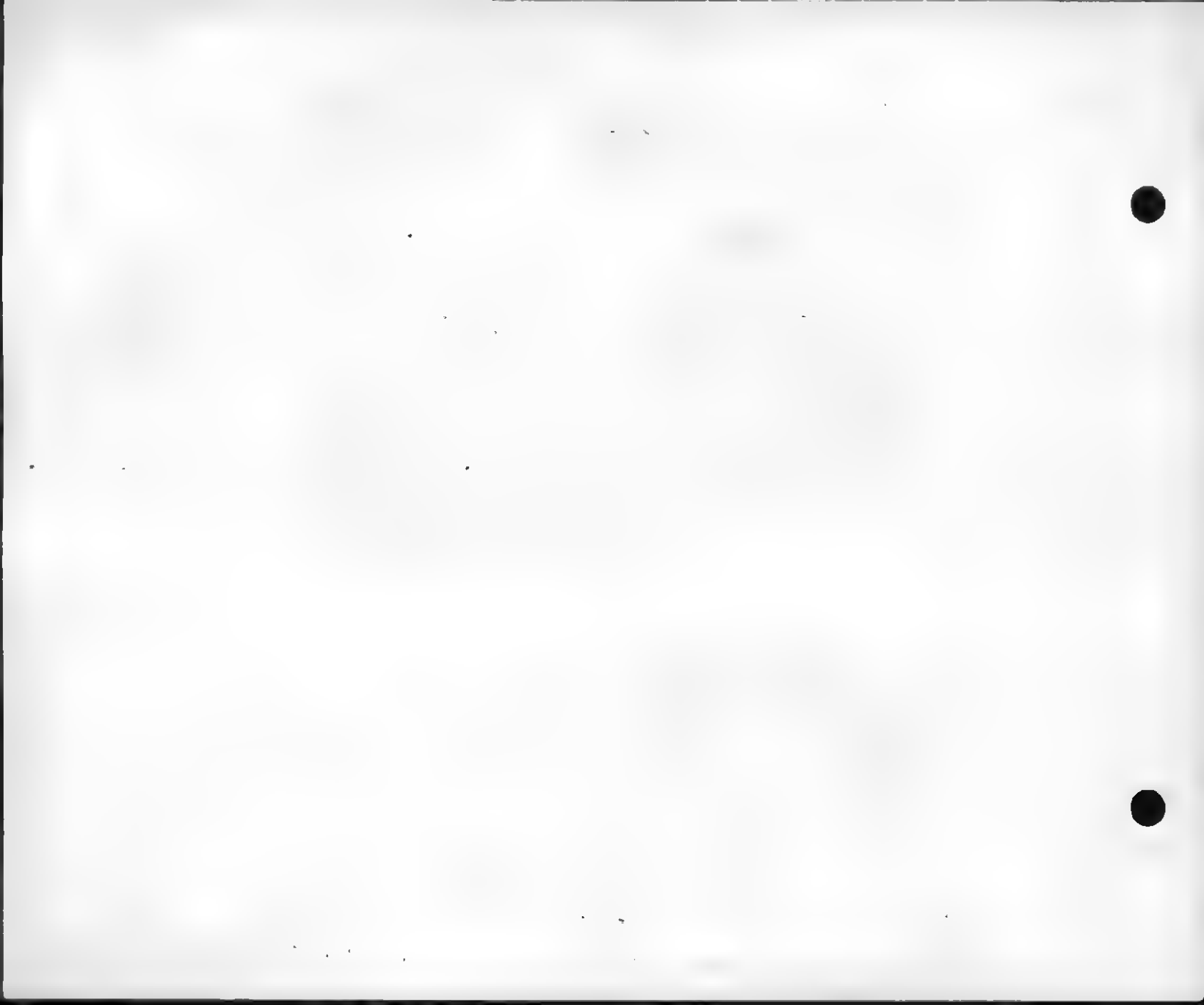
13650

13645

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN TB <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>5TH E. FORT AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>WALSH</u> Last <u>TO</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1883</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT SMITH</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215 05 535TD</u>	
17. INFORMANT <u>MRS. EILEEN HELLMAN</u>		Address <u>5406 Summerfield Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>1531</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> , 19 <u>68</u> , to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-14</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M., from causes and on the date stated above			
22a. SIGNATURE <u>Wilmer K. Gallager</u>		22b. DATE SIGNED <u>10/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>		22d. ADDRESS <u>6209 Frederick Ave. Balt. Md 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Green Burial AA Md.</u>
24. FUNERAL DIRECTOR <u>McLully</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>	
ADDRESS <u>130 E. Fort Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



31

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12645

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13651

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie 21212</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abnessen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>804 Maxalea Court</u>		d. STREET ADDRESS <u>207 Schell Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Michael T. Wanko</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 6, 1895</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Guard-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Wanko</u>		14. MOTHER'S MAIDEN NAME <u>Margaret ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>Family records</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Renal</u> DUE TO <u>5 yr</u> (c) <u>Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Oct. 23, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Belle Vernon Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Belle Vernon, Penna.</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25. REGISTRATION DATE <u>OCT 23 1967</u> REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

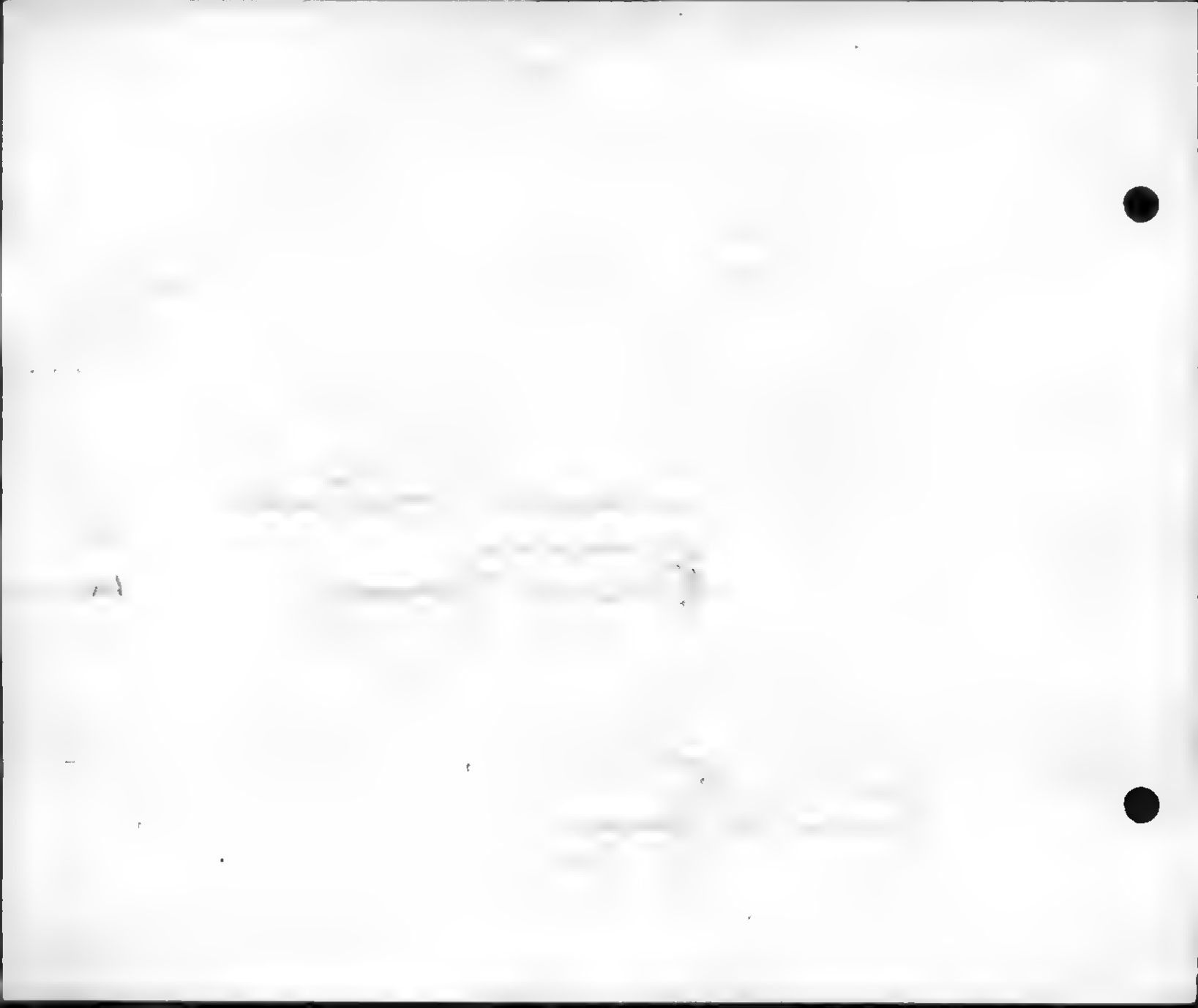


CERTIFICATE OF DEATH

13652

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 16		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS 6402 Blenheim Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Richardson WEBSTER		4. DATE OF DEATH Month Oct. Day 7 Year 19 67		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-2-62		9. AGE (In years lost birthday) 5 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James McCormick Webster		14. MOTHER'S MAIDEN NAME Nancy Jane Menton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) tracheo-bronchial obstruction DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) infectious DUE TO Klebsiella Pneumonia (c) 1 month		INTERVAL BETWEEN ONSET AND DEATH hrs. wks 1 month		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
21. I certify that (I) (this hospital) attended the deceased from Feb. 2 , 19 67 , to Oct. 7 , 19 67 that (I) (we) last saw the deceased alive on Oct. 7 , 19 67 , and that death occurred at 11A M, from causes and on the date stated above.		22a. SIGNATURE Richard A Jones M.D.		22b. DATE SIGNED 7 Oct, 67		22c. PHYSICIAN'S NAME (Type) Richard A Jones M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Oct. 10, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Govan's		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Road		25a. REC'D BY REGISTRAR OCT 11 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

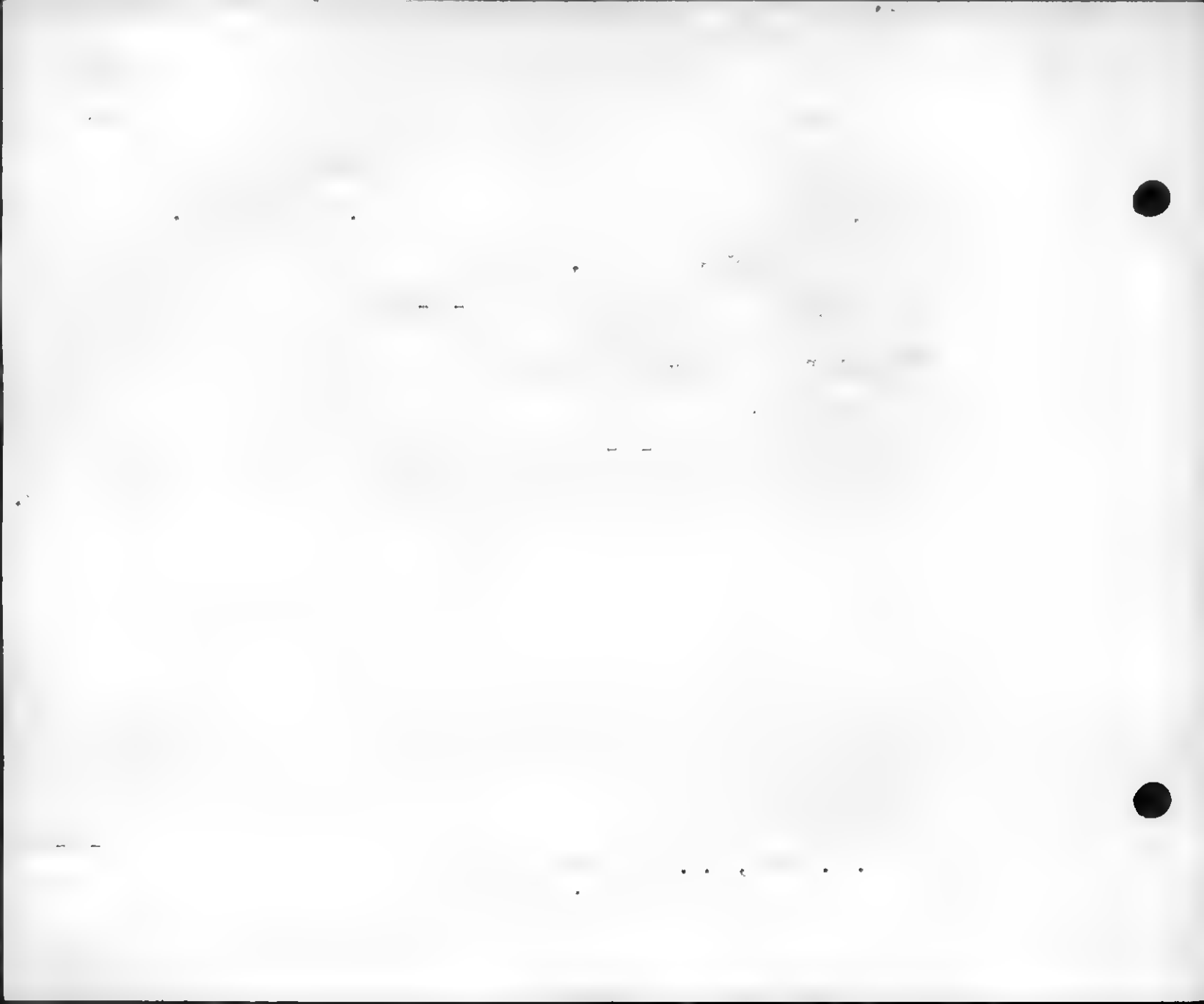
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13653

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Plant Dispensary		d. STREET ADDRESS 119 N. Symington Ave.	
3 NAME OF DECEASED (Type or print) First Charles Middle J. Last WEDEKIND		4 DATE OF DEATH Month 10 Day 18 Year 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-30-1918
9 AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 10 Days 18 Hours 19 Min 67	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Steel Making	
11 BIRTHPLACE (State or foreign country) Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles J. Wedekind		14 MOTHER'S MAIDEN NAME Carrie Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-1118	
17. INFORMANT <i>Mr. Charles J. Wedekind</i>		Address <i>119 N. Symington Ave.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion T201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH one (1) hr.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> N		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) O N	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>M. B. Davis</i>		22. DATE SIGNED 10-18-67	
EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Morningside Rd		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-21-67	
23c. LOCATION (City or town) (County) (State) Baltimore Md.		23d. LOCATION (City or town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR <i>Foley-Corway D.F.H. - Catonsville, Md.</i>		25a. REC'D BY REGISTRAR OCT 23 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

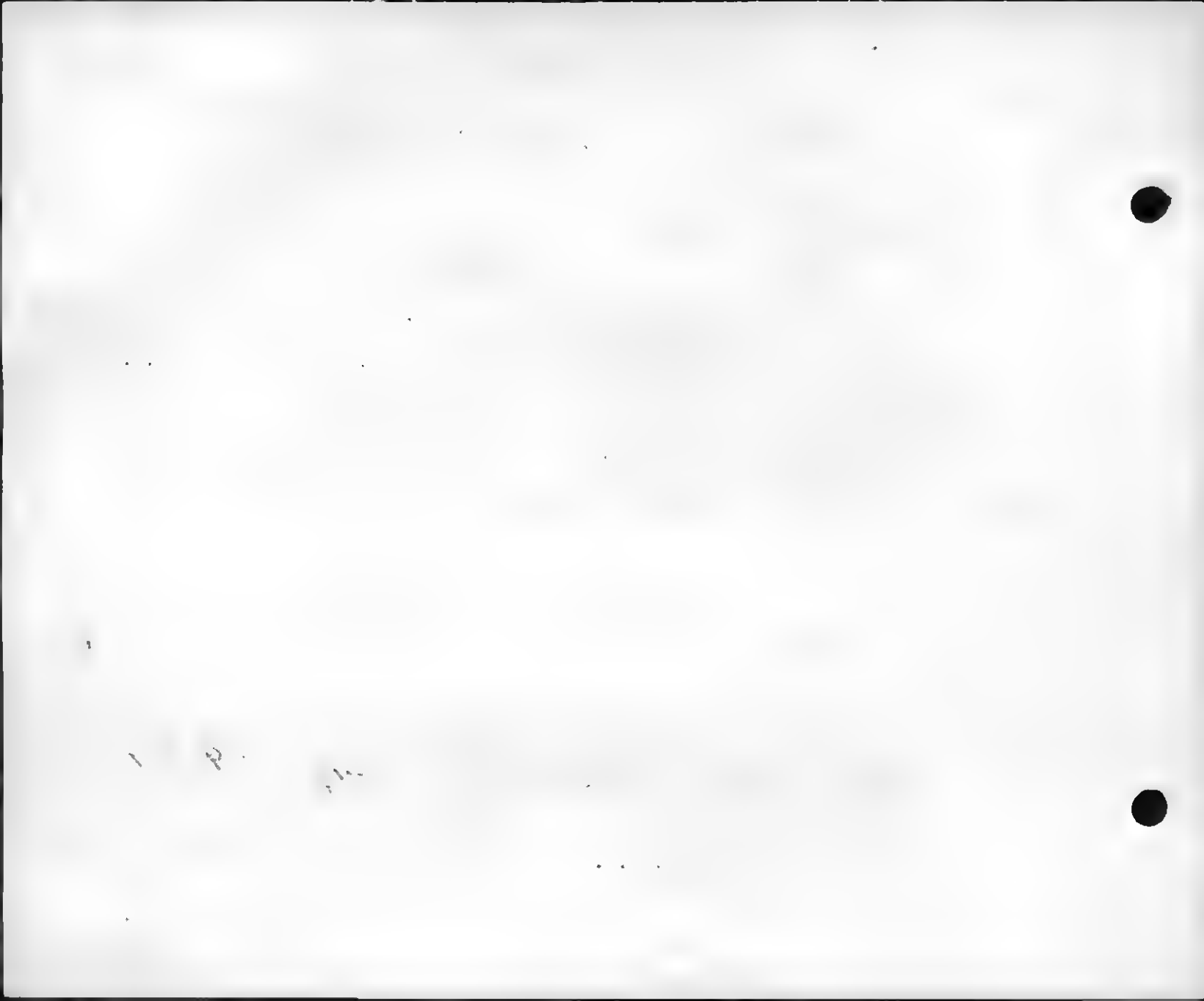


TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div style="display: flex; justify-content: space-between;"> <div> <p>13049 Item #4 Film #G393 10/11/67 ph</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>13654</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital					d. STREET ADDRESS 917 North Kresson Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle V. Last Wehrheim					4. DATE OF DEATH Month Oct. Day 9 Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1921		9. AGE (In years last birthday) 46 yrs IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: _____	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk			10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Wehrheim					14. MOTHER'S MAIDEN NAME Minnie VanSant				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____			16. SOCIAL SECURITY NO 217142021		17. INFORMANT Address Records: Spring Grove State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH _____	
								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain Tumor									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>July 28</u>, 19 <u>62</u> to <u>Oct 9</u>, 19 <u>67</u>, that (X) (we) last saw the deceased alive on <u>Oct 9</u>, 19 <u>67</u>, and that death occurred at <u>7:15</u> M, from causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar					22b. DATE SIGNED M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.	
22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/11/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane					25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

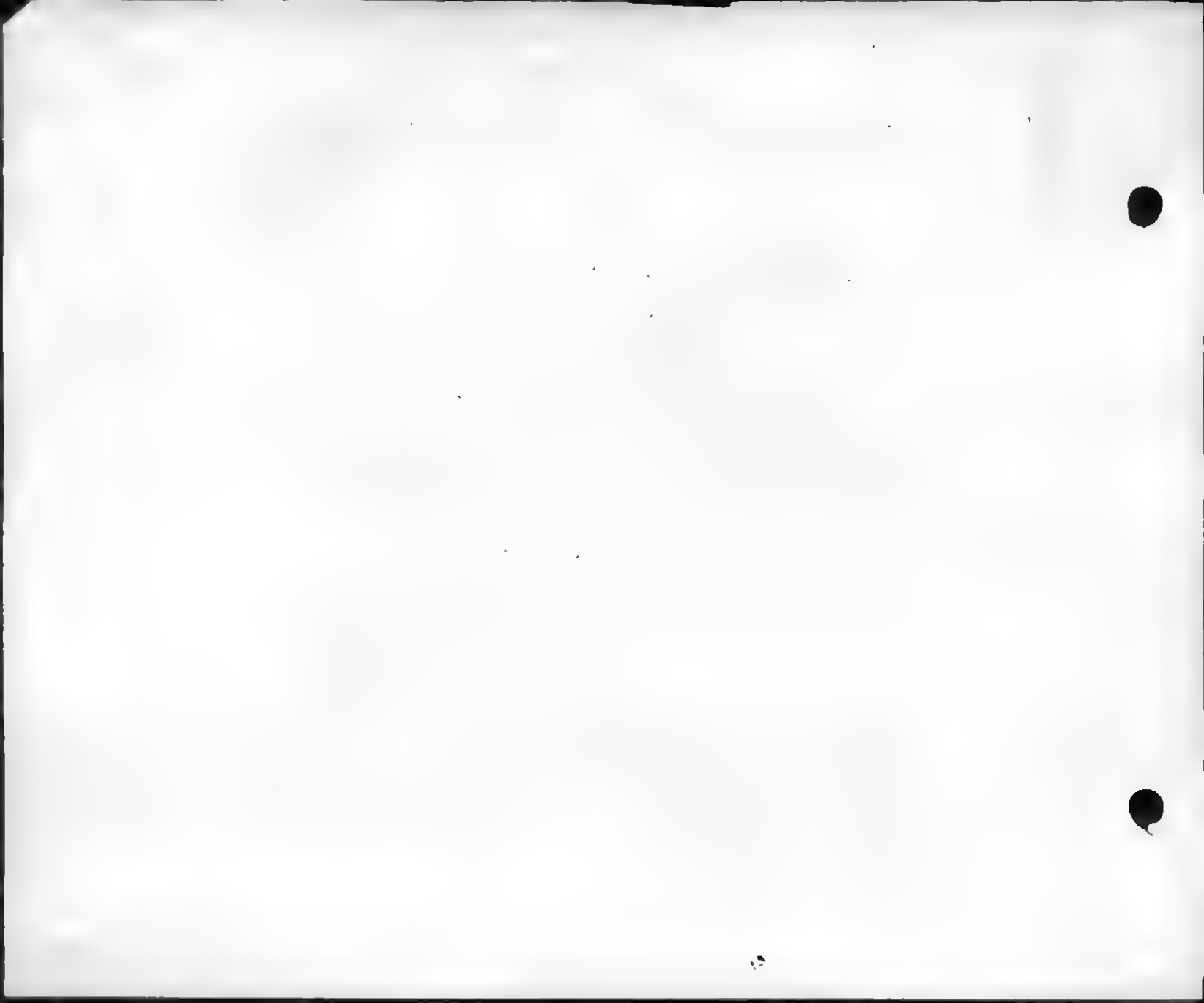
13650

13655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN TB <u>19 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE-CITY - 21213</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>3307 ELMORA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY MATTHEWS WELLS</u>				4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1898</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State or foreign country) <u>BALTIMORE CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM BELTMAN</u>				14. MOTHER'S MAIDEN NAME <u>FRANKLIN, ROSE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Admission SHEET —</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Lympho Sarcoma</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> , 19 <u>67</u> , to <u>10/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>67</u> , and that death occurred at <u>8:20 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Abthian</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Abthian</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10-28-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Elkridge, Maryland</u>	
24. FUNERAL DIRECTOR <u>John C. Miller Inc. - 4415 Belair Road - 21204</u>				25a. REC'D BY REGISTRAR <u>Charles Judges</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judges</u>	

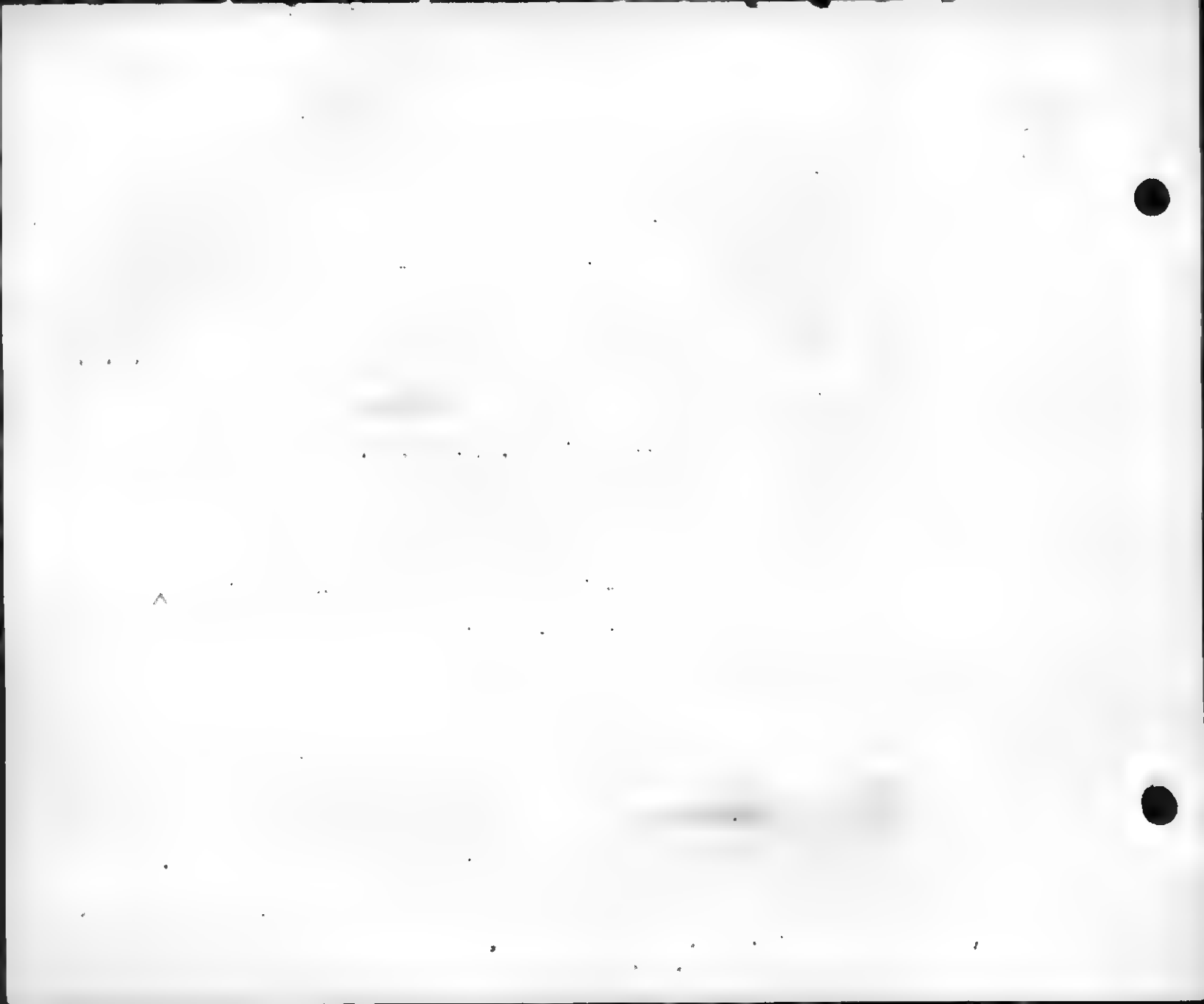


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13051					13656				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Baltimore			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson, Baltimore			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 21236		
c. LENGTH OF STAY IN 1b		35 Days			d. STREET ADDRESS		8219 Belair Road		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Greater Baltimore Medical Center									
3. NAME OF DECEASED (Type or print)		First Middle Last			4. DATE OF DEATH		Month Day Year		
VIVIAN		JULIA			WELLS		October 13, 1967		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/21/1899		68 yrs.	Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			Own Home		Budapest, Hungary		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Joseph Janosek					Anna Lehotsky				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		217-07-0190		J.M. Boyd, Jr.,		706 Stevenson Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Peritonitis									
DUE TO			(b) Ileocolic fistula and perforated duodenal ulcer						
DUE TO			abdominal aorta						
DUE TO			(c) Post-operative-state - Resection of aneurysm of						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Arteriosclerotic cardiovascular disease									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
Hour a.m. p.m.	19	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from September 7, 1967, to October 13, 1967, that (I) (we) last saw the deceased alive on October 13, 1967, and that death occurred at 4:40 AM, from the causes and on the date stated above.									
22a. SIGNATURE					AM ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		
John E. Adams							10/13/67		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
John E. Adams, M.D.					Greater Baltimore Med. Center				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Cremation		10/16/67		Greenmount		Baltimore Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					OCT 16 1967 Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1-67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15139

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, first institution Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS Notchcliff - Villa Maria	
3 NAME OF DECEASED (Type or print) First Middle Last Sister Orosa Mary Wernsdorfer		4 DATE OF DEATH Month Day Year October 29, 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 20, 1881
9 AGE (in years last birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min 10 24 00 00	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? Maryland	
13 FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO Not Known	
17 INFORMANT Convent Records		Address VILLA MARIA, MD.	
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) + 42X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic cardiovascular Vascular system (c) Ischemic heart disease		INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Fracture of Left Hip		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH Fall from Chair onto floor		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fall from Chair onto floor	
20c. TIME OF INJURY Month, Day, Year 2:45 a.m. 10/26/67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Notchcliff Glenarm Md		20f. (City or town) (County) (State) Notchcliff Glenarm Md	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 301 W. Preston Street, Baltimore, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct 31, 1967	
23c. NAME OF CEMETERY OR CREMATORY SISTERS CEMETERY		23d. LOCATION (City or Town) (County) (State) GLENARM MARYLAND	
FUNERAL DIRECTOR RAYMOND J CURRAN		25a. REC'D BY REGISTRAR NOV 14 1967	
ADDRESS 817 SCARLETT DR TOWSON, MD. 21204		25b. REGISTRAR'S SIGNATURE William J. Jones	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

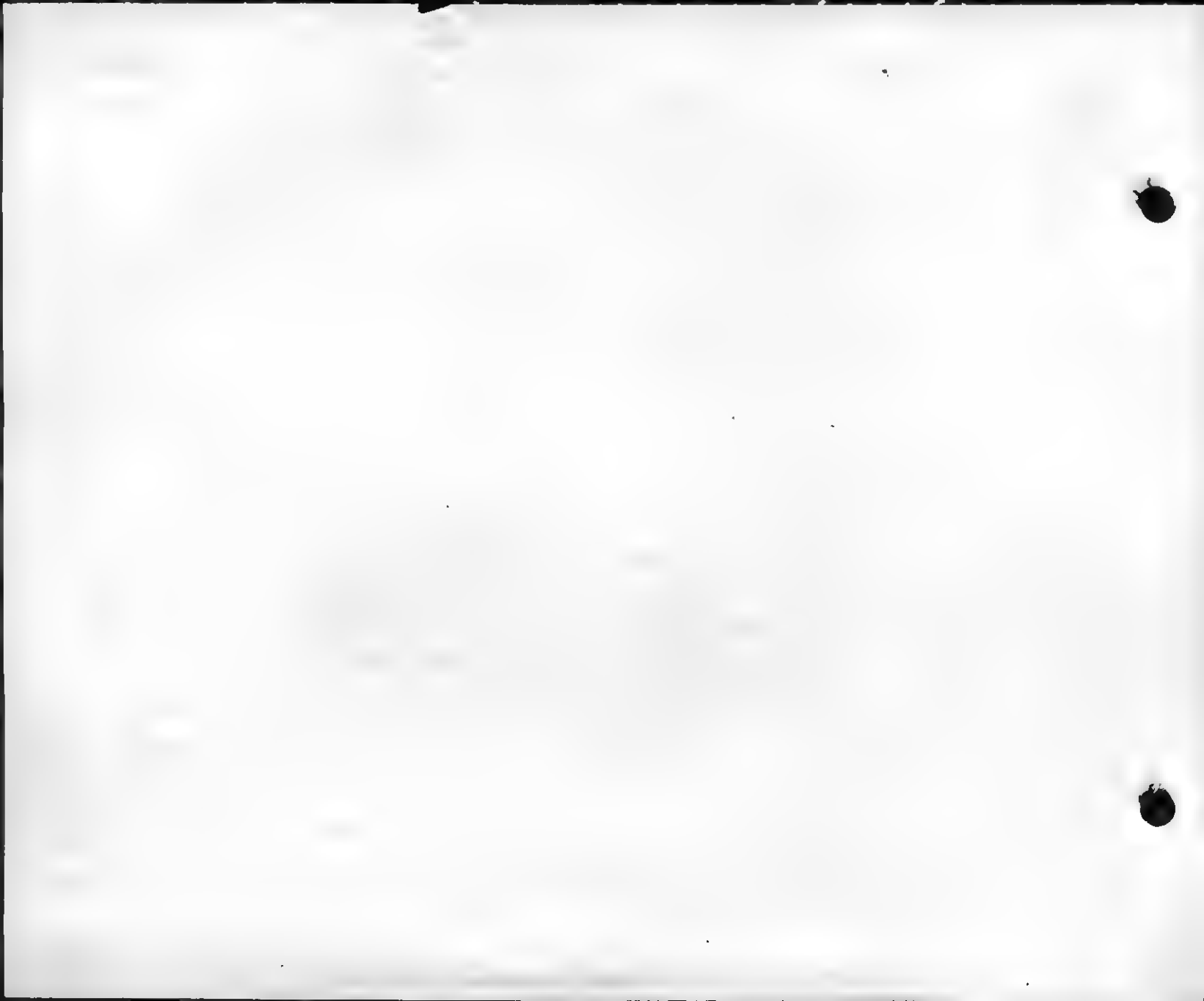
CERTIFICATE OF DEATH

13657

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-la Nursing Home</u>		d. STREET ADDRESS <u>8040 Philadelphia Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine E. Wheeler</u>		4. DATE OF DEATH <u>10/29</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/95</u>
9. AGE (In years/last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CIT ZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown JACOB WEBER</u>		14. MOTHER'S MAIDEN NAME <u>Unknown MYERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Hort. Chart-</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>67</u> , to <u>10/28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/28</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>David E. Zickfoose</u> M.D.		22b. DATE SIGNED <u>10/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David E. Zickfoose</u>		22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>E.S. MALNABB</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

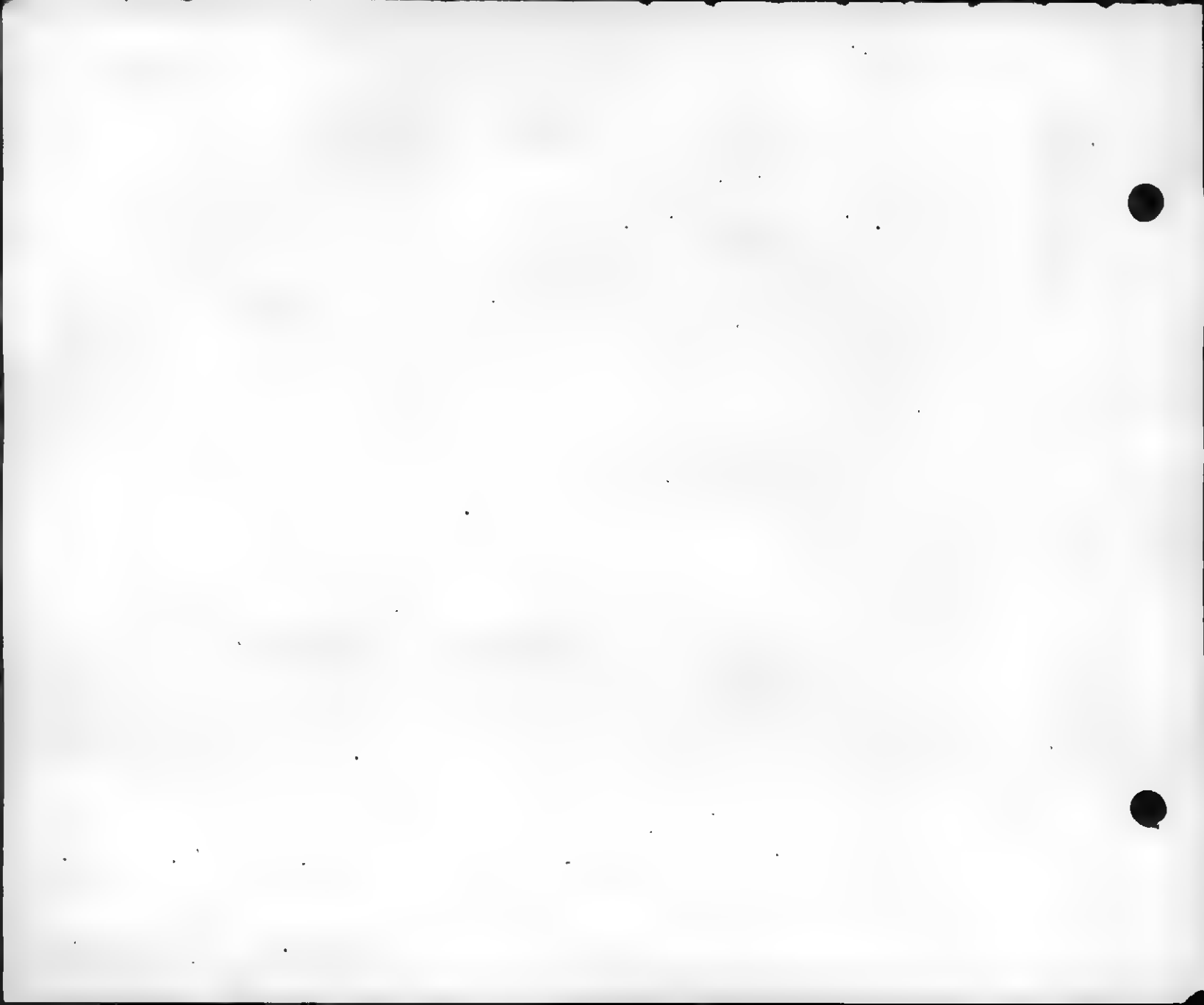


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>1209 ST. AGNES LANE</u> ^{APT. H}	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1209 ST. AGNES LANE</u>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDGAR</u> First <u>EUGENE</u> Middle <u>White</u> Last		4. DATE OF DEATH <u>OCT. 25</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 13, 1885</u> 81 AGE (In years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Relig's</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Blackburg S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jos. White</u>		14. MOTHER'S MAIDEN NAME <u>MARGAROT SHARP</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>141-22-5665</u>	
17. INFIRMANT Address <u>EDGAR E. WHITE JR. 1209 ST AGNES LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rt Lung</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1966</u> to <u>Oct 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 25, 1967</u> , and that death occurred at <u>1030 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John N. Snyder</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10/25/67</u>
22c. PHYSICIAN'S NAME (Type) <u>JOHN N. SNYDER MD</u>		22d. ADDRESS <u>6348 FREDERICK RD CATONSVILLE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>10/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAUREL HILL</u>	23d. LOCATION (City, town or county) (State) <u>Phila, PA.</u>
24. FUNERAL DIRECTOR ADDRESS <u>WM COOK-BROOKS INC 1217 ST. PAUL ST.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 30 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13655

13659

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson			c. LENGTH OF STAY in 1b 2 mos 13 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital				d. STREET ADDRESS Texas, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle WHYE Last WHYE				4. DATE OF DEATH Month 10 Day 23 Year 1967			
5. SEX M.	6. COLOR OR RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/9/1919		9. AGE (In years last birthday) 48 yrs	IF UNDER 1 YEAR Months 10 Days 23 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Whye				14. MOTHER'S MAIDEN NAME Annabeta Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-0263		17. INFORMANT Address Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, DUE TO 2 METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/10/1967 , to 10/23/1967 , that (I) (we) last saw the deceased alive on 10/23/1967 , and that death occurred at 5 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent	
22d. ADDRESS Mount Wilson, Maryland				22e. ADDRESS Mount Wilson, Maryland		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-67		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem.		23d. LOCATION (City or Town) (County) (State) Balto. Md	
24. FUNERAL DIRECTOR Mocton Dyer Fitt				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2056

13660

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>504 Brook Road</u>		d. STREET ADDRESS <u>504 Brook Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Alma</u> Last <u>Wickman</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1890</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernst Domeschke</u>		14. MOTHER'S MÄDEN NAME <u>Wilhelmina -- Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-14-7366D</u>	
17. INFORMANT <u>Ruth Chelf, 504 Brook Rd.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder (transitional cell)</u> 1510 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>October 20, 1966</u> , to <u>10/2, 1967</u> , that (1) (we) last saw the deceased alive on <u>9/29</u> 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Smyth, M.D.</u>		22b. DATE SIGNED <u>Oct 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>Oct 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13651 Item #2d Film 43394 10/20/67 ph CERTIFICATE OF DEATH 13661											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home						d. STREET ADDRESS 2107 Drummon Rd. 1002 N. Rolling Rd.					
3. NAME OF DECEASED (Type or print) Maude O. Wiest						4. DATE OF DEATH 10 18 19 67					
5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/82		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME George Miller						14. MOTHER'S MAIDEN NAME Mary E. Robey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-22-3512		17. INFORMANT Mr. Russell Miller 15 Oberlin Ct. Balt. Md. 4					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcohol - chronic - vascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Post-nephritic.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 , to Oct 18, 1967 , that (I) (we) last saw the deceased alive on Oct 17, 1967 , and that death occurred at 8 P. M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						22b. DATE SIGNED 10/20/67					
22c. PHYSICIAN'S NAME (Type) [Signature]						22d. ADDRESS [Signature]					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/21/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Balt. Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Balt. Md. 4						25a. REC'D BY REGISTRAR DATE OCT 26 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

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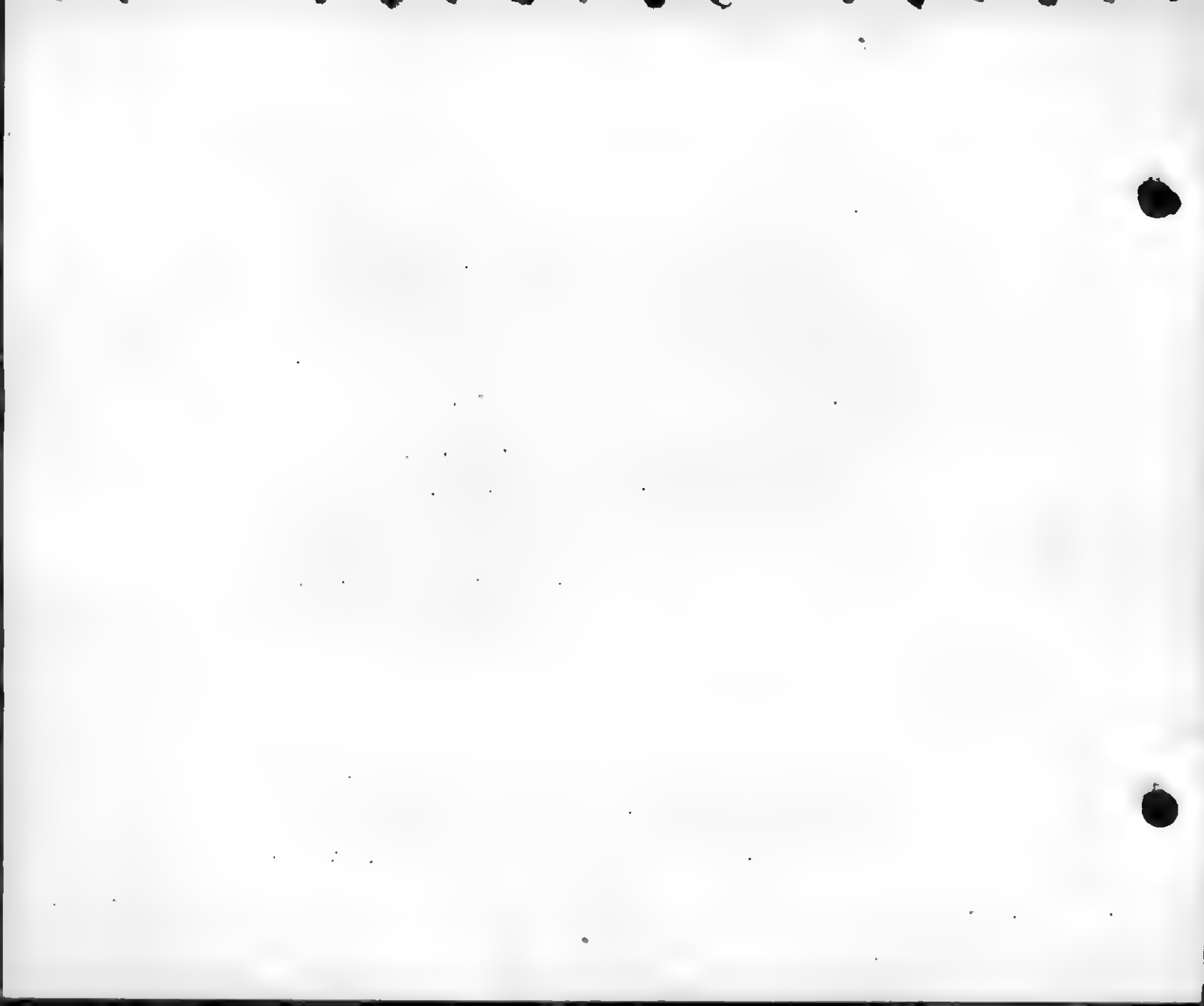
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13682											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) White Hall</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>William</u>						4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>19 67</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/20/47</u>		9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patient's Chart</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> <u>110X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma to lungs</u> DUE TO (c) <u>Carcinomatosis, primary site undetermined</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 1967, to <u>10/11</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/11</u> , 1967, and that death occurred at <u>1:50M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John E. Adams</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. am. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>John E. Adams, M.D.</u>						22d. ADDRESS <u>6701 N. Charles Street</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>10-14-67</u>		<u>Mt. Calvary Cnty.</u>		<u>Penne Prindel Co. Md.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Randolph J. Collick 2431 E. Oliver St.</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		
						DATE <u>OCT 13 1967</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

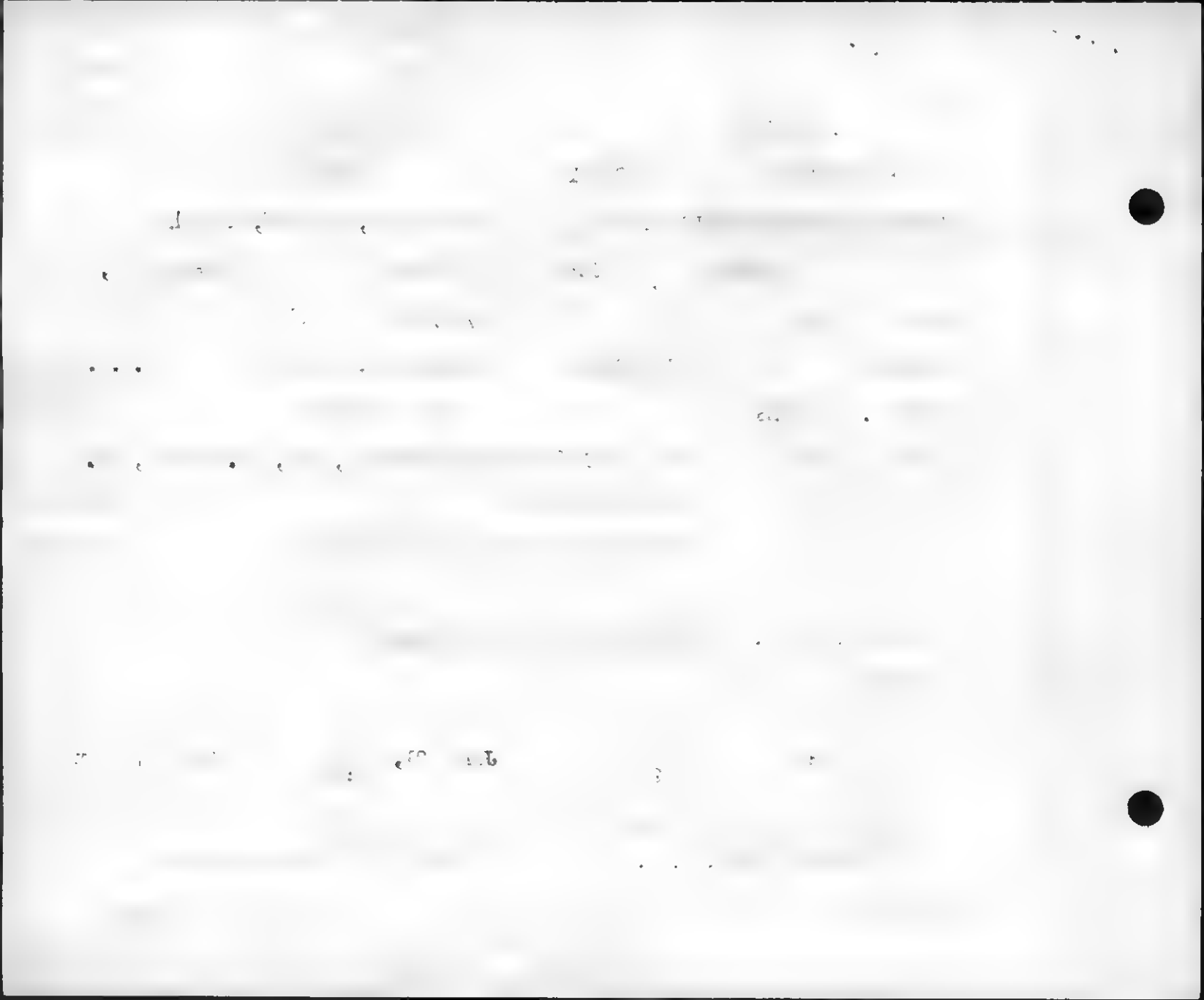
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13663

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 99 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS OLD MILL RD, BOX #25, RFD #4	
3 NAME OF DECEASED (Type or print) First CLINTON Middle LEE Last WILLIAMS		4. DATE OF DEATH Month OCTOBER Day 28 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/96
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY J. WILLIAMS		14. MOTHER'S MAIDEN NAME JANE PHILLIPS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 214 38 81 61	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) BRONCHOGENIC CARCINOMA RIGHT LUNG DUE TO (c) UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA, LUNGS. ARTERIOSCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from JULY 21, 1967 to OCT 28, 1967 , that he (we) last saw the deceased alive on OCT 28 1967 , and that death occurred at 8:00PM , from causes and on the date stated above.			
22a. SIGNATURE <i>George Budas</i>		22b. DATE SIGNED 10/30/67	
22c. PHYSICIAN'S NAME (Type) GEORGE BUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1 NOV 67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR NOV 1 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

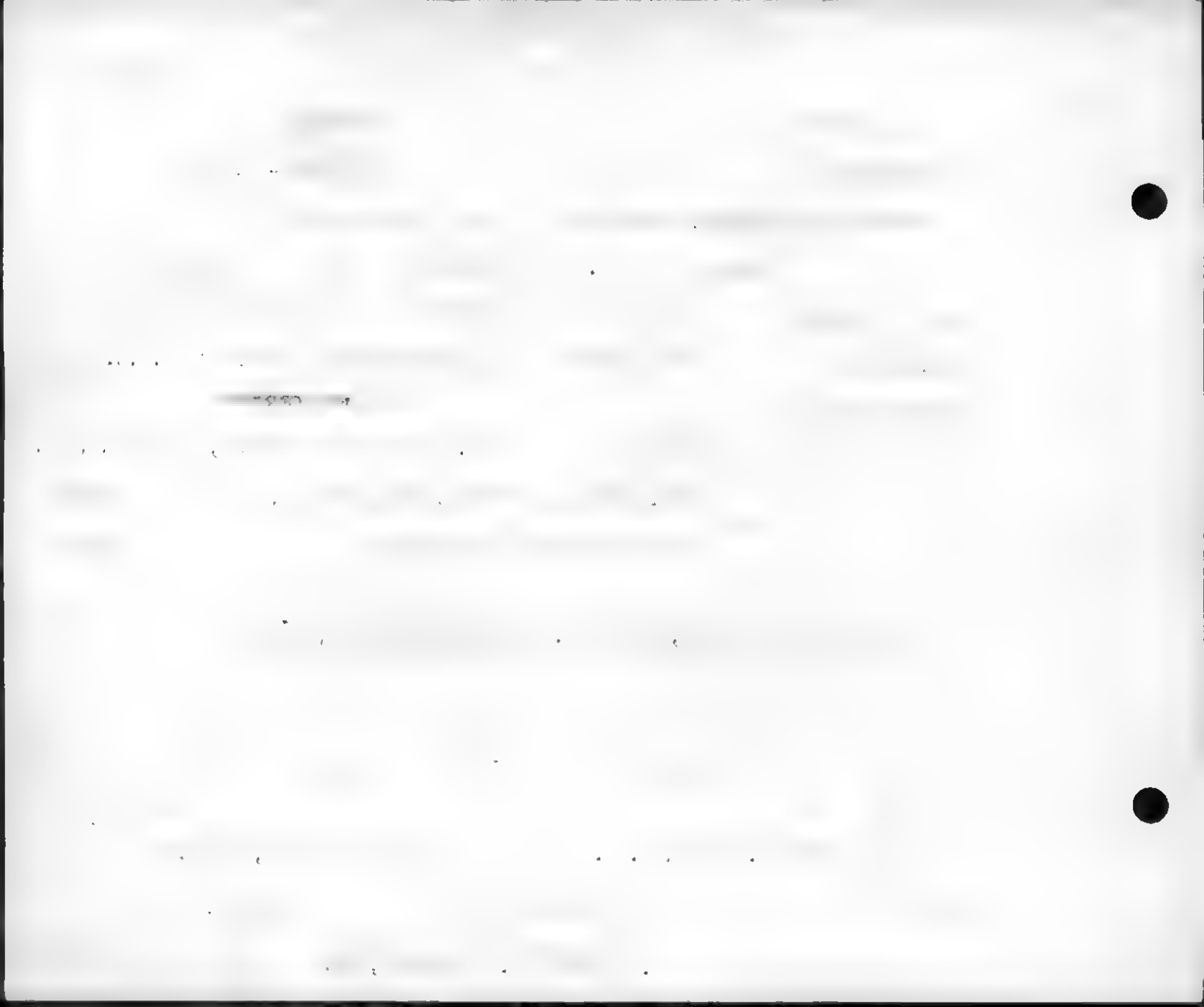
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13664

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 219 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2016 RUXTON AVENUE	
3. NAME OF DECEASED (Type or print) First HOMER Middle C. Last WILLIAMS		4. DATE OF DEATH Month OCTOBER Day 8 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY FOOD MARKET	9. AGE (In years last birthday) yrs. 74
11. BIRTHPLACE (County & State, or foreign country) AUGUSTA COUNTY, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT WILLIAMS		14. MOTHER'S MAIDEN NAME HANNAH WALKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218 05 56 88	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, FAR ADVANCED, ACTIVE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN		INTERVA. BETWEEN ONSET AND DEATH UNKNOWN	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME, CLINICAL. DIABETES MELLITUS, CLINICAL		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (the deceased) attended the deceased from 3/3/67 , 19 to 10/8/67 , 19, that (he) (we) last saw the deceased alive on 10/8/67 , 19, and that death occurred at 9:10A , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-11-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME		25. REC'D BY REGISTRAR 11 1967	
ADDRESS E. LAURENS ST. BALTIMORE, MD.		26. REGISTRAR'S SIGNATURE <i>James J. Juvan</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

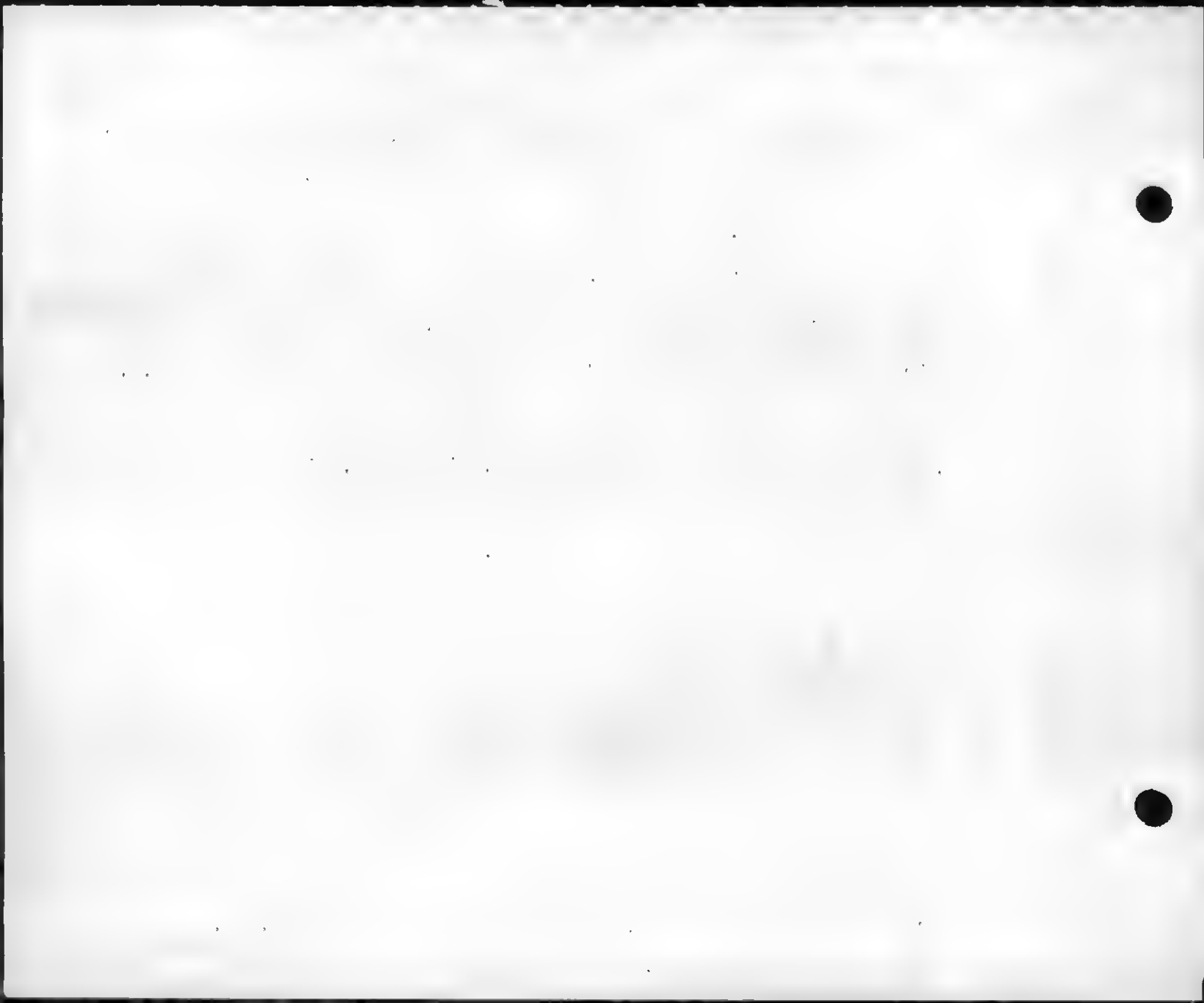
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13665

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 Murdock Rd.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge d. STREET ADDRESS 20 Murdock Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leonard C. Wilson		4 DATE OF DEATH Month 10 Day 18 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 18, 1897
9 AGE (In years last birthday) 70 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11 IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired accountant		10b. KIND OF BUSINESS OR INDUSTRY Can Co	
11. BIRTHPLACE (County & State, or foreign country) Ottawa, Canada		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Wilsonn		14 MOTHER'S MAIDEN NAME UNK.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 108 10 1511	
17. INFORMANT Mrs. Violette J. Wilson		Address 20 Murdock Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CVD DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH MINUTES 4RS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis & Rt hemiplegia			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1965 to Oct 18, 1967 , that (I) (we) last saw the deceased alive on Oct 18, 1967 , and that death occurred at 11:30 M. from causes and on the date stated above.			
22a. SIGNATURE A. T. Venable Jr		22b. DATE SIGNED 10-18-67	
22c. PHYSICIAN'S NAME (Type) S. J. VENABLE JR M.D.		22d ADDRESS 7215 York Rd. BALTIMORE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 10/21/1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24 FUNERAL DIRECTOR Mitchell Windefeld		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Home 6500 York Rd		DATE OCT 24 1967	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

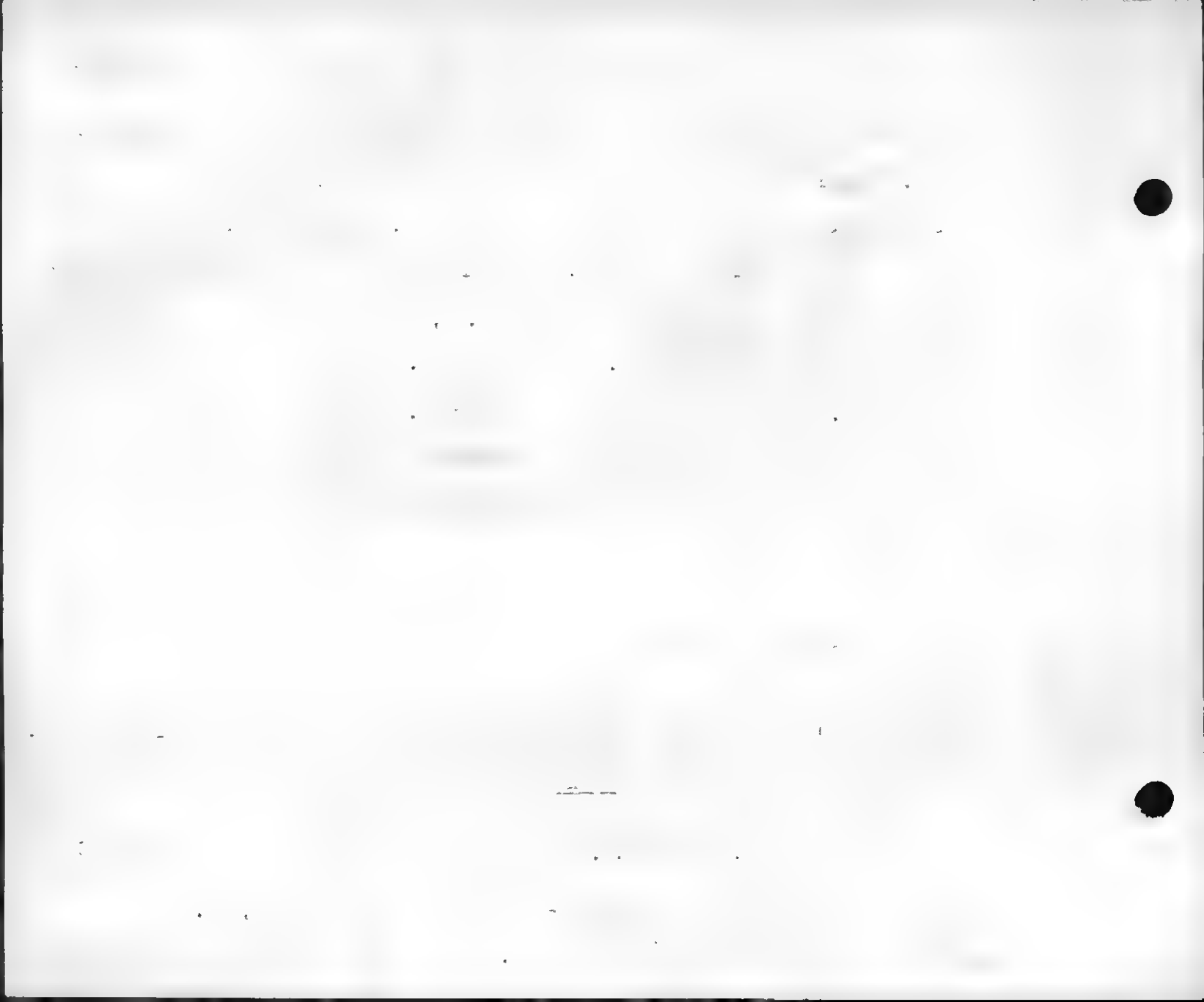
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13666

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard		c. LENGTH OF STAY IN 1b Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Howard Hospital		d. STREET ADDRESS 215 A. Woodvale Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		c3-1	
3. NAME OF DECEASED (Type or print) WILLIAM A. WILSON, JR		4. DATE OF DEATH Month October Day 31 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1895
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Wilson		14. MOTHER'S MAIDEN NAME Nancy E. Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO 213 07 0310A	
17. INFORMANT Margaret McWilliams		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of left hip		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell and sustained injury to left hip	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9/1/ p.m. 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Nursing Home		20f. (City or town) (County) (State) Baltimore, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 10/31/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Prudzinski Funeral Home 1407 Eastern Ave.		25a. REC'D BY REGISTRAR DATE Nov 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1d 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 7844 Rockbourne Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Lou C Winterling First Middle Last 5. SEX Female 6. COLOR OR RACE Cau. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2/22/30 9. AGE (In years last birthday) 37 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary 10b. KIND OF BUSINESS OR INDUSTRY Maryland Title 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.						4. DATE OF DEATH 10 17 1967 Month Day Year 13. FATHER'S NAME Edward Finnerty 14. MOTHER'S MAIDEN NAME Lillian Foll 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 212-28-8696 17. INFORMANT (Husband) Albert C. Winterling Address Dundalk, Md. 21222 7844 Rockbourne Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic disseminated lupus erythematosus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1967 , to Oct. 17, 1967 , that (I) (we) last saw the deceased alive on Oct. 17, 1967 , and that death occurred at 12:00 , from the causes and on the date stated above.											
22a. SIGNATURE John E. Adams 22b. DATE SIGNED 10/17/67 22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D. 22d. ADDRESS 6701 N. Charles Street 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10/19/67 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem. 23d. LOCATION (City, town or county) Baltimore, Md.											
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. 25a. REC'D BY REGISTRAR 10/18/67 25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>											

1951

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

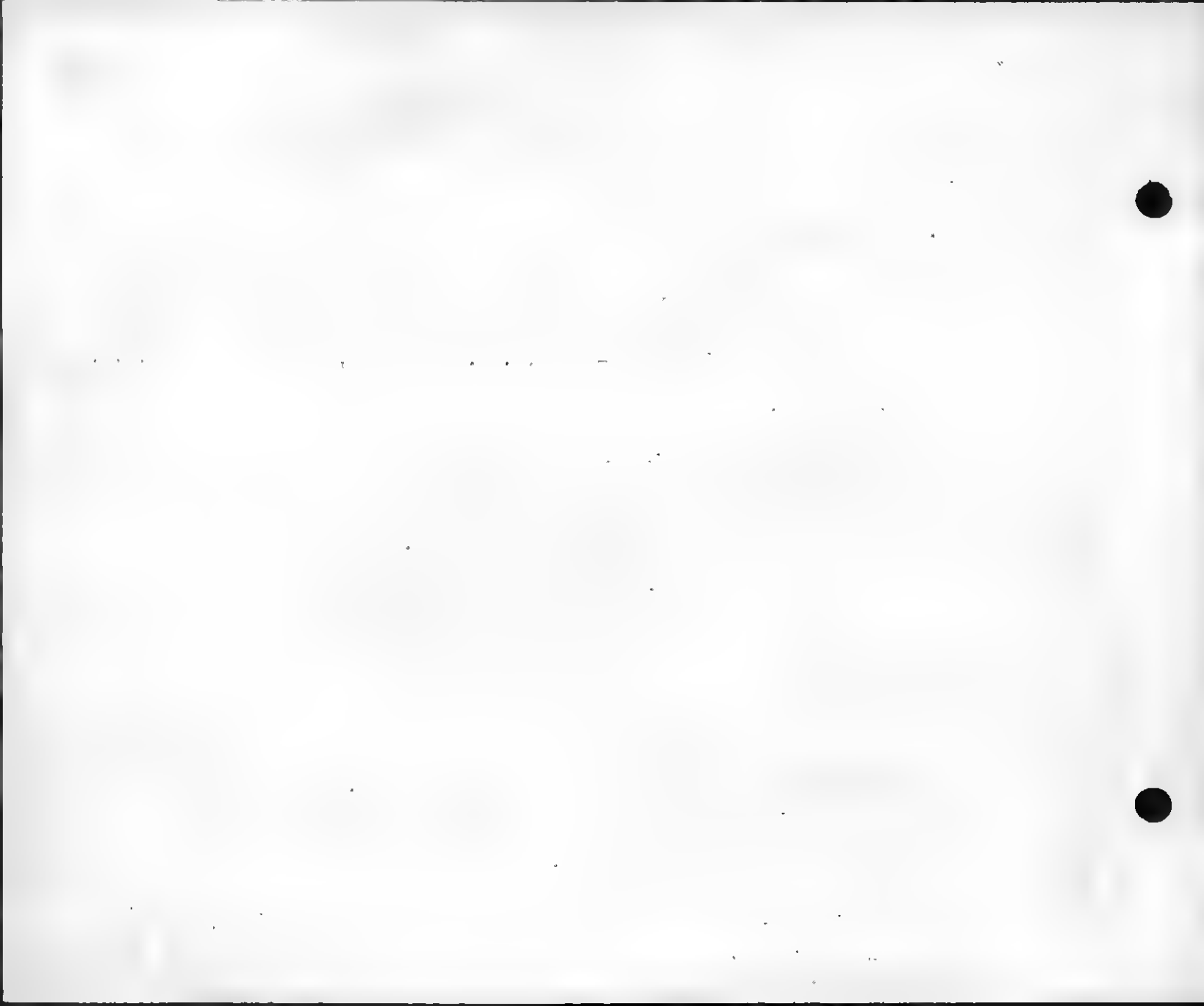
CERTIFICATE OF DEATH

13668

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Welch	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 68 Maple Terrace	
3. NAME OF DECEASED (Type or print) First Middle Last Roger WOODS		4. DATE OF DEATH Month Day Year October 20 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1941
9. AGE (In years lost birthday) 26 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY City Hall-Welch, W. Va.	
11. BIRTHPLACE (County & State, or foreign country) Marion, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Wood		14. MOTHER'S MAIDEN NAME Margie Glass	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 235-62-9094	
17. INFORMANT Leonard Wood		Address Welch, West Virginia	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) Chronic glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 27 1967 , to October 20 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 20 1967 , and that death occurred at 4:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Misanik</i>		22b. DATE SIGNED 11/20/67	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit	23b. DATE THEREOF 10-22-67	23c. NAME OF CEMETERY OR CREMATORY Yeager Memorial	23d. LOCATION (City or Town) (County) (State) Roadfield West Virginia
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212		25a. REC'D BY REGISTRAR DATE OCT 24 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

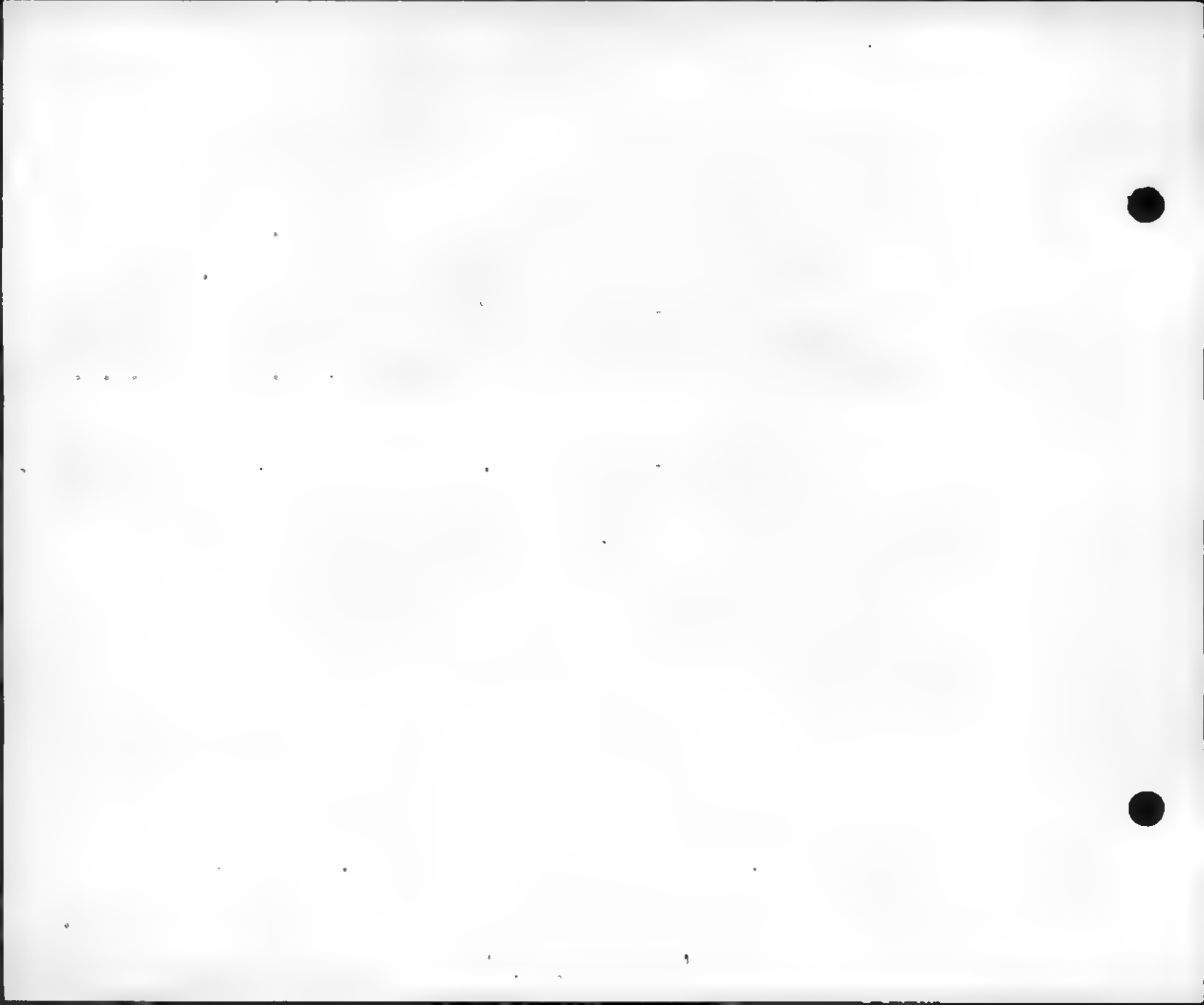
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13669

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN IT			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home				d. STREET ADDRESS Wyman Park Apts.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gertrude Middle C. Last Wright				4. DATE OF DEATH Month Oct. Day 8 Year 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1886		9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Feick				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-48-4500		17. INFORMANT Mrs. Frank Symington, 103 Overhill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Central Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertensive cardiovascular disease DUE TO cerebral (c) cerebral						INTERVAL BETWEEN ONSET AND DEATH one day 15-20	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/18, 1955 to 10/8, 1967 that (I) (we) last saw the deceased alive on 10/7, 1967 and that death occurred at 5 P. M, from causes and on the date stated above							
22a. SIGNATURE William J. Renner				22b. DATE SIGNED 10/9/67		22c. PHYSICIAN'S NAME (Type) Dr. William Renner	
22d. ADDRESS 3222 St. Paul St.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co., 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13670

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 mths 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS Homeless	
3. NAME OF DECEASED (Type or print) First Edward Middle Young Last		4. DATE OF DEATH Month October Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (in years last birthday) 60? yrs		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (County & State, or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ?		16. SOCIAL SECURITY NO ?	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage, acute, site DUE TO Undetermined, characterized by massive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) rectal bleeding. Suspect carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Azotemia, malnutrition, chronic alcoholism.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 31, 1967 , to October 7, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct 7 19 67 , and that death occurred at 1:33M , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		22b. DATE SIGNED 22.10.67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 13 1967	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Old Frederick Road Balto Md	
24. FUNERAL DIRECTOR Klaus Funeral Home 1216 S Charles St #30		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

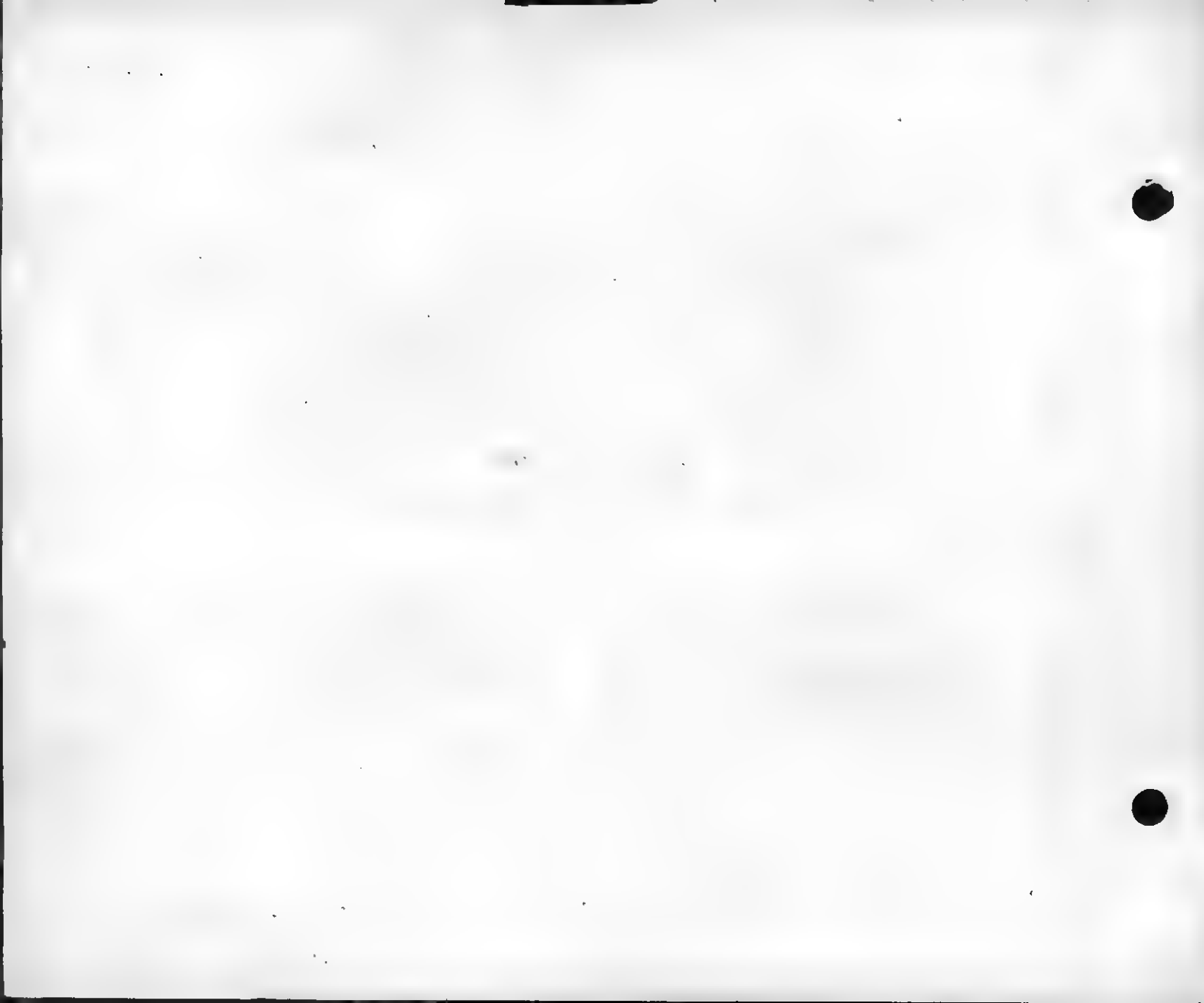
CERTIFICATE OF DEATH

13671

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>Arbutus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines N.H.</u> <u>16 Fasting Ave.</u>		d. STREET ADDRESS <u>5210 Leeds Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK ZACCARI, JR.</u>		4. DATE OF DEATH Month Day Year <u>10 / 9 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/84</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. F UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sol Zaccari</u>		14. MOTHER'S MARDEN NAME <u>Anna Cicero</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-7854</u>	
17. INFORMANT <u>Anna Zaccari</u>		Address <u>5132 Westland Blvd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fibrosarcoma right scapula with</u> <u>1964</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastasis</u> DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>Oct. 9</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Oct 9</u> , 19 <u>67</u> , and that death occurred at <u>7:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Herbert J. Levickas</u> M.D.		22b. DATE SIGNED <u>10/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		22d. ADDRESS <u>5404 East Drive</u>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Maryland</u>
24. FUNERAL DIRECTOR <u>Amber Inc. 1328 Sulphur Sp. Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 16 1967</u>	25b. REGISTRAR'S SIGNATURE <u>William Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13865

13672

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. LENGTH OF STAY IN 1b 6 mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2230 HAWTHORNE RD		e. STREET ADDRESS 608 MARYLAND AVE	
3. NAME OF DECEASED (Type or print) ERNEST M. ZIMMERMAN		4. DATE OF DEATH Month OCT. Day 24 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 1, 1903
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 03 Days 01	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BREW MASTER		10b. KIND OF BUSINESS OR INDUSTRY BEER	
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO. 216-05-4081	
17. INFORMANT ERNEST J ZIMMERMAN		Address 2230 HAWTHORNE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Cancer of Lung			INTERVAL BETWEEN ONSET AND DEATH 15 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 63 , to Oct , 19 67 , that (I) (we) lost saw the deceased alive on Oct , 19 67 , and that death occurred at 8 P. M., from causes on and on the date stated above.			
22a. SIGNATURE J. Lyden		22b. DATE SIGNED 10/25/67	
22c. PHYSICIAN'S NAME (Type) J. LYDEN		22d. ADDRESS 6402 GOLDEN RIVE RD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/28/67	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	23d. LOCATION (City or Town) (County) (State) BALTO. MD
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25a. REC'D BY REGISTRAR 300 MACE	
25b. REGISTRAR'S SIGNATURE John J. Judge		25c. DATE OCT 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

13869

13873

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 114 Hopkins Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 114 Hopkins Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine R. Zipprian		4. DATE OF DEATH Month Day Year October 16 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William W. Rathbone		14. MOTHER'S MAIDEN NAME Ida Basil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-54-0930	
17. INFORMANT Alfred I. Zipprian		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) A-S Heart disease DUE TO (c) 2 yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's disease & cerebral A.S.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from 7/3, 1963 to 10/16, 1967 , that (I) (was) last saw the deceased alive on 10/16, 1967 , and that death occurred at 7A M. from causes and on the date stated above.			
22a. SIGNATURE Norman R. Freeman M.D.		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) Dr. Norman R. Freeman		22d. ADDRESS 11 W. 29th St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

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